TOWARDS A PSYCHODYNAMICALLY-INFORMED MODEL FOR THE INTEGRATIVE PSYCHOTHERAPEUTIC TREATMENT OF MALE SEXUAL DYSFUNCTION

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Declaration

This thesis is the result of original work by the author Michael D. Berry. Where information has been drawn from other sources it has been appropriately acknowledged.

This dissertation is not the same as any that has been submitted for a degree or diploma or other qualification at any other university.

No part of this dissertation has already been or is being concurrently submitted for any such degree, diploma or other qualification.

Signed

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Dedicated to Ceara Crawshaw,
who is more supportive and loving
than I ever could have asked.

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Abstract

Introduction:

Empirical research on sex therapy appears to be a significant and growing area in the social sciences, with researchers evaluating the use of a variety of different psychotherapy modalities in the treatment of male sexual problems. However, although clinical literature suggests that sex therapists may use psychodynamic techniques in their clinical practice, current empirical research on the place of psychodynamic methods in the sex therapy field is negligible. This research project aims to help fill this gap. The primary aim of this research project is to identify the role of psychodynamic methods in sex therapy. The principal research question underlying this work is: *to what extent do psychosexual therapy specialists currently employ psychodynamic therapy techniques in treating men's sexual dysfunctions*?

A number of secondary aims also guided this research programme. This work aimed to gather data on:

- the ways in which sex therapists conceptualize and use the biopsychosocial model,
- the diagnostic and assessment protocols they use with male clients,
- the methods they use in establishing clinical goals and developing case formulations,
- the ways in which sex therapy specialists conceive of and assess the aetiology of male sexual problems, and
- the place that psychodynamic versus cognitive behavioural therapy (CBT) techniques play in the treatment of male sexual dysfunction.

The role of psychodynamic theory and technique was considered in relation to all of these factors.

Methods:

To evaluate these issues, this research project used a combination of: 1) a questionnaire-based survey, administered to practitioners in the sex therapy field, and 2) interviews with sex therapists and subject matter experts. The questionnaire sample

consists of specialist sex therapists, and psychotherapy generalists who have experience in treating male sexual dysfunction. By examining the differences in technique reported by these two populations, this research sought to establish what is unique about psychosexual therapy, and what specific role psychodynamic techniques play within this specialization. The qualitative data generated from the interviews were used to clarify the integrative practices by which psychodynamically-based theory and technique are included in the treatment of male sexual dysfunction.

Results:

The data indicate that both sex therapists and psychotherapy generalists make use of prototypical and distinctive psychodynamic techniques to a significant degree in their work treating male sexual problems. Sex therapists report using psychodynamic and CBT techniques to approximately the same degree. Psychotherapy generalists report a higher level of adherence to psychodynamic techniques than sex therapists.

Sex therapists report a high level of endorsement of the biopsychosocial model, and report drawing on a range of psychotherapy frameworks, including psychodynamic methods. A high level of focus on psychosocial and relational factors is reported, and attachment theory is identified as a key clinical factor in sex therapists' work. The data suggest that sex therapists view insight—including insight into unconscious factors—as an important element of the therapeutic change process.

Conclusions:

The data indicate that psychodynamic theory and technique are integral to sex therapy practices. Often, however, psychodynamic techniques may be used implicitly and psychosexual therapists may not explicitly recognize their perspective as psychodynamic. Additionally, psychodynamically-informed techniques that focus on the client's relationships, early life and development, and gaining insight into aetiology, may be of particular importance in the sex therapy field, and represent an area for future research.

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Table of Abbreviations

AASECT	American Association of Sexuality Educators, Counselors and Therapists
ANOVA	Analysis of Variance
APA	American Psychiatric Association
BACP	British Association for Counselling and Psychotherapy
BASRT	British Association for Sex and Relationship Therapy
BDSM	Bondage/Discipline, Dominance/Submission, Sadism/Masochism
BPC	British Psychoanalytic Council
BPS	British Psychological Society
BPS model	Biopsychosocial model
CBT	Cognitive-Behavioural Therapy
COSRT	College of Sexual and Relationship Therapists
df	degrees of freedom
DSM	Diagnostic and Statistical Manual
EAP	Employee Assistance Program
ED	Erectile Dysfunction
GP	General Practitioner
ICD	International Classification of Diseases
ISSM	International Society for Sexual Medicine
LGBTQ	Lesbian, Gay, Bi-sexual, Trans., Queer
LUTS	Lower Urinary Tract Symptoms
M	Mean
MBT	Mentalization-Based Therapy
NHS	National Health Service

PDE5is	Phosphodiesterase-5 Inhibitors
PE	Premature Ejaculation
PG	Psychotherapy Generalist
PLISSIT	Permission, Limited Information, Specific Suggestions, Intensive Therapy
pred.-prec.-perp.	Predisposing, Precipitating and Perpetuating/Maintaining
REB	Research Ethics Board
RF	Reflective Function
RCT	Randomised Clinical Trial
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences
SSSS	Society for the Scientific Study of Sexuality
SSRI	Selective Serotonin Reuptake Inhibitor
ST	Sex Therapist
SSTAR	Society for Sex Therapy and Research
TCCR	Tavistock Centre for Couple Relationships
UKCP	United Kingdom Council for Psychotherapy
UCL	University College London
WHO	World Health Organization

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SECTION 1

CHAPTER 1. REVIEW OF PSYCHODYNAMIC PRACTICE IN BIOPSYCHOSOCIAL SEX THERAPY

Are psychodynamic techniques and theories still relevant in the field of sex therapy? The foundational work of early sex therapy pioneers was largely cognitive behavioural in orientation, often self-consciously to the exclusion of psychoanalytic practices (Bancroft, 2005; Masters & Johnson, 1966; Masters & Johnson, 1970; Segraves, 1986), and clinical literature indicates that in recent decades the sex therapy specialization has moved towards a biopsychosocial model grounded in these fundamentally cognitive behavioural principles and techniques (McCabe et al., 2010; Simopoulos & Trinidad, 2013; Wincze & Carey, 2001). Furthermore, research suggests that there has been a mutual separation between sex therapy and psychoanalytic/psychodynamic practice in recent years, marked also by a lessened degree of attention to sex and sexual functioning in psychodynamic research (Shalev & Yerushalmi, 2009). Just as the sex therapy field has shifted away from psychodynamic practice, this body of research suggests, psychodynamic research has shifted away from sexological concerns.

Nonetheless, there are numerous indicators both within the sex therapy literature (Berry, 2013b; Hartmann, 2009; Waldinger, 2006, 2013), and within the wider psychotherapy literature (Fonagy, 2008a; Shedler, 2010; Westen, 1998, 2000), that psychodynamic theories and methods may continue to exert significant influence over the psychotherapeutic treatment of sexual problems. Empirical research on the current use of psychodynamic methods in sex therapy practice, however, is fundamentally lacking. This thesis is intended to help fill this gap.

This research project sought to determine the extent to which sex therapy specialists (ST), as compared with psychotherapy generalists (PG), report using psychodynamic theories and techniques in treating men's sexual problems, and this dissertation describes the results of a two-part study that comprises the empirical research-base for this work. A questionnaire was administered, and completed by 159 psychotherapists and counsellors, and a set of research interviews was conducted with 34 psychotherapists, sex therapists and sexologists. The project evaluated the role of psychodynamic practice in sex therapists' work, considering the dominant practices in psychotherapeutic sex therapy.

The data collected through this study are intended to clarify the role of psychodynamic theory/practice within the wider biopsychosocial treatment context of contemporary sex therapy by assessing the ways in which psychodynamic theory/technique fit within the key practices of sex therapy. Specifically, the study aims to determine whether sex therapists use psychodynamic theories and techniques in assessing sexual dysfunctions and developing case formulations, and in treating male sexual dysfunctions. Consequently, this study also evaluates clinicians' self-reported use of integrative and biopsychosocial practices, the diagnostic and assessment protocols used by ST specialists, the techniques therapists use in establishing clinical goals and case formulations, and in their work with diverse client populations, and the understandings that sex therapists hold about the aetiological factors underlying sexual dysfunction. This dissertation presents data on the psychotherapeutic treatment of male sexual dysfunction, and specifically on the use of core psychodynamic principles within this wider treatment context.

1.1. Towards a Psychodynamically-informed Treatment for Male Sexual Dysfunction: Psychological Research in a Biomedical Era

Ours is an era of biomedical and pharmacological cures, a historical moment marked by the shift towards tangible, pill-in-hand treatments. This widely-noted trend, which has elsewhere been described as an unrelenting push for "magic bullet" solutions to both simple and complex health problems (Berry, 2013a), may be driven by a number of factors including: the physicalist turn in the epistemology of the health sciences (Hellman & Thompson, 1975; Marcum, 2008), a political and infrastructural pressure to maximize utility and efficiency in our healthcare systems, and by patients' understandable desire for expedient, physically and emotionally non-invasive treatments (Tiefer, 2006). Within the sexual sciences, this trend has taken the form of a well-documented and broadly debated "Viagra revolution" which researchers and clinicians have described as, minimally, a new stage in the evolution of sexual therapies, and potentially a pointed threat to the place of psychotherapy in the treatment of sexual problems (DeRogatis, 2007; Rowland, 2007).

While evidence indicates that monistic biomedical treatment approaches may be prevalent amongst medical generalists (Tiefer, 2007; Tsimitsiou et al., 2006), it is clear that such biomedical and pharmacological reductionism is opposed by the biopsychosocial standards, and process of care guidelines, of sexual healthcare (Lue, Basson, et al., 2004; Montorsi, Basson, et al., 2010). Additionally, in research,

practice, and professional development, an integrative biopsychosocial treatment model is widely supported by sexual health specialists, who have recognized the need to develop further the empirical evidence-base for comprehensive sexual treatment (Berry & Berry, 2013a). This research area is predicated on the conceptualization of sex therapy as an evolving and integrative system of practice, which draws on a range of therapeutic methodologies with the aim of providing complete and coherent biopsychosocial treatment for sexual dysfunction (Althof, 2006b, 2010b). Prominent authors in the field assert the importance of psychosocial interventions and the ongoing need for empirical research to establish the place of psychotherapeutic methods, alongside medical treatment options, in the biopsychosocial/integrative treatment of sexual problems (McCabe et al., 2010; McCarthy & Fucito, 2005; McCarthy & McDonald, 2009a; Perelman, 2005a).

It is additionally important to note that pharmaceutical treatments—particularly psychotropic medications—can directly affect sexual functioning, adding to the complexity of the interactions between psychosocial and physiological aspects of sexual behaviour and sexual problems. It is well established, for instance, that widely prescribed medications, including those used to treat depression, anxiety and other emotional difficulties, may cause or exacerbate problems in sexual functioning through both their physiological and psychological effects (Andersson, 2011; Apantaku-Olajide, Gibbons, & Higgins, 2011; Chan et al., 2011; Porst, 2011; Serretti & Chiesa, 2011; Strohmaier et al., 2011; Traish, Hassani, Guay, Zitzmann, & Hansen, 2011). Consequently, differentiating the aetiological contributions of psychological and physiological factors—including pharmaceutical treatments—is a complex task. For some clients, emotional difficulties lead to pharmaceutical treatment, which may appear to be the core aetiological factor in an emergent or worsening sexual problem. However, in practice, the underlying emotional concern may be the primary causal factor in the sexual problem, underscoring the importance of integrative, biopsychosocial, and psychologically-informed treatment procedures, which can differentiate the likely contributions of both physiological and psychosocial factors.

In the psychotherapeutic arena, researchers and clinicians alike indicate that sex therapy is an integrative discipline—a model that carries both advantages and challenges (Leiblum, 2007b). Sex therapy's overarching, apparently integrative paradigm offers a wide range of tools and a flexible treatment approach that enables the integration of varied psychotherapy techniques alongside insights from related

disciplines and theoretical frameworks (Binik & Hall, 2014). However, some researchers caution that therapeutic eclecticism may foster a risk of methodological fragmentation and diffusion (Kleinplatz, 2003). As Levine emphasizes, "there has to be some standard about what we do—whether we are psychodynamic, cognitive-behavioural, or behavioural in our approach. A touch of this, a dab of that, and a pinch of 'my new theory' ultimately diminishes the standing of sex therapists" (2007a, p. 451). As with any healthcare model, sex therapy requires methodological standards, and the integrative, biopsychosocial treatment approach requires empirical research foundations.

This research dissertation aims to make an empirical contribution to the research on psychotherapeutic sex therapy, by determining the amount of influence that psychodynamic techniques and theories still exert over the self-reported application of psychotherapeutic interventions in the sex therapy realm. Although psychoanalytic and psychodynamic techniques appear to have fallen into disfavour in much of the sex therapy field, a number of research-oriented clinicians have explicitly advocated their value in the conceptualization and treatment of sexual difficulties (Daines & Perrett, 2000; Kaplan, 1974b; Levine & Althof, 1991; Segraves, 1986).[1] However, this body of literature is exceedingly limited, particularly with respect to contemporary practice. Additionally, research that evaluates the role of psychodynamic theory/technique within an *integrative* model, which considers the current principles and practices (i.e. diagnosis, assessment, goal-setting and intervention) from a biopsychosocial vantage point, is essentially inexistent. This dissertation is intended to help fill this gap in our knowledge of psychosexual therapy practice.

1.1.2. Rationale for this Study: Sex Matters

Despite the aforementioned divide between psychodynamic/psychoanalytic research and sexological research, early psychoanalysts—Freud in particular—placed sex and sexuality within a position of primacy within the psychic life of the individual, and as a root factor that brought individuals into the consulting room. In fact, "psychical impotence" as Freud understood it was—alongside anxiety in its myriad forms—the most common impetus for treatment-seeking amongst male

[1] Defining the actual role of psychodynamic practices in sex therapy is a much-needed task. Reviews of current principles and practices in sex therapy emphasize the high level of psychotherapy integration in current practice, and vaguely acknowledge that psychodynamic methods are currently used (Althof, 2010b; McCabe et al., 2010). However, despite this noted trend towards integration of psychotherapy modalities in the sex therapy field, the actual degree and means of application of

psychoanalytic patients (Freud, 1961f/1912). Hence, just as sexuality was construed as a core aspect of human experience, sexual problems were seen as a fundamental, widespread and urgent concern. Contemporary sexologists and sex therapists, it may be argued, accord a comparable level of importance to sexuality within the range of human experience, and a similar level of priority to psychosexual treatment.

However, research suggests that sexuality is an area of the client's life that can be profoundly challenging to address within healthcare systems. Current data indicate that limitations in psychologist and psychotherapist training programs with respect to sexual issues (Reissing & Giulio, 2010; Wiederman & Sansone, 1999), and comparable training limitations and infrequent sexual history taking amongst physicians, are common (Athanadiasis et al., 2006). Even more problematically, some clinical training may actively deter trainee clinicians from initiating discussions about the patient's sex life. "During my own training," Kahr writes,

> more than one of my teachers had counseled us against introducing the subject of sexuality as part of the clinical interview. And yet, all of my clinical experience with couples has revealed how many difficulties they have in speaking about sex with one another, let alone with the psychotherapist, leading me to believe that it would be unkind not to offer a gentle enquiry in order to facilitate verbalization (2009: 6).

Highlighting this trend of avoidance, it appears that sex therapists, sexologists and sex researchers routinely bemoan their non-specialist colleagues' apparent discomfort with, and avoidance of, sexual material and topics. Within the clinical sphere, more research is needed to determine how psychotherapists may justify the avoidance of sexual topics in the consulting room. A number of sex therapists interviewed in this research project suggest that, in some cases, health practitioners may see the client's sex life as extraneous or irrelevant to the primary points of clinical interest, particularly in cases wherein a client is to be treated for a specific—and not overtly sexual—problem. Yet, it is clearly impossible to evaluate the important, and often unanticipated, role that sex may play in the client's psychosocial concerns without introducing it as a topic for discussion.

Overall, sex therapists interviewed for this research emphasize that sex and sexuality can be difficult and uncomfortable topics for many psychotherapists. "Too often," as Risen writes,

> therapists find themselves reluctant to initiate an inquiry [about sex]. They rationalize, 'If my patient doesn't bring sex up, it must not be an issue, and I

should not be asking about it.' At best, this can lead to a missed opportunity to be helpful; at worst it can lead to the wrong therapy plan (2010, p. 4).

Moreover, the challenges associated with sexual topics, belie the fact that sexual health and functioning correlate with a number of essential measures of psychological, physical, and relational health (Brotto, Petkau, Labrie, & Basson, 2011; Davies, Katz, & Jackson, 1999; Goldstein, 2000; King, Juenemann, Levinson, Stechar, & Creanga, 2007; Laumann, Paik, & Rosen, 1999). As sex researchers emphasize, sex is a crucial aspect of personal well-being, often under-acknowledged in the healthcare arena (Binik & Hall, 2014). Simply put, research clearly indicates that in contemporary healthcare systems in general, and in mental healthcare specifically, sex matters. This research evaluates how psychodynamic methods contribute to this area of importance.

1.1.3. Rationale for this Study: Psychoanalysis (Still) Matters

It has been, rightly, argued that just because a clinician has a couch in the consulting room does not mean they are a psychoanalyst, and that it is important to avoid overestimating the current influence of psychodynamic theory (Kelman, 1954). It is equally important, however, to note that collective and individual methodological, epistemological, or aesthetic objections to certain aspects of Freud's work do not justify an exhaustive dismissal of psychoanalytic or psychodynamic methods. Psychoanalytic and psychodynamic researchers routinely describe this encompassing disregard as "throwing the baby out with the bathwater," and this research project is based on the premise that psychodynamic techniques continue to be of significant value in the psychotherapeutic field (Kirman, 1998; Luyten, Blatt, & Corveleyn, 2006). Consequently, this dissertation explores the questions: are psychodynamic methods currently used in the area that was of such vital importance in Freud's own work—sexuality? What contribution do psychodynamic theories and techniques make to the treatment of sexual problems, today?

The term 'psychodynamic' is used to designate a range of techniques and principles, and as there is no universal consensus on its precise meaning, it is necessary to outline clearly how psychodynamic practices are conceived in this research project (see also chapter 4, section 4.4). Regardless of the variances in its conceptualization, 'psychodynamic' methods, by definition, have evolved out of Freud's work, and psychoanalysis is foundational to psychodynamic practice. As with psychoanalysis, Bateman et al. stress, psychodynamic psychotherapy takes the

individual's inner mental life as an essential point of focus, and the psychodynamic psychotherapist is "concerned with approaching the patient empathetically from the *inside* in order to help him [sic.] to identify and understand what is happening in his [sic.] inner world" (2010, p. 3, ital. in orig.). This approach, they assert, takes insight, or *knowledge of self,* as a key goal and as a means for psychotherapeutic growth/healing. Another core assumption of contemporary psychodynamic practice, noted by Luyten and colleagues, is the importance of a "person-centered" approach, in which "the focus is always on the person and his or her developmental history rather than solely on one particular symptom, disorder, or developmental outcome" (Luyten, Mayes, Target, & Fonagy, 2012, p. 426). Within this "person-centered" framework, psychodynamic practice emphasizes the exploration of early life and developmental factors, including experiences within the individual's family of origin. Consequently, strong links have been forged between psychodynamic methods and other psychotherapeutic schools, including attachment theory (Luyten et al., 2012).

It is, therefore, especially important to note that, while an array of psychotherapeutic techniques are uniquely informed by psychodynamic theory, applied psychodynamic practice shares key theoretical and practical elements with other psychotherapy models, including cognitive behavioural therapy (Bateman et al., 2010). In fact, the apparent tension between cognitive behavioural therapy and psychodynamic therapy may be more an artefact of disciplinary politicking and rhetoric, than clinical methodology, as comparative clinical trials routinely show comparable efficacy for both treatment frameworks (Leichsenring, 2001; Leichsenring, Hiller, Weissberg, & Leibing, 2006; Stiles, Barkham, Mellor-Clark, & Connell, 2008; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006). Additionally, a substantial body of research indicates that a significant proportion of psychotherapists take an integrative approach, drawing on theory and technique from a variety of psychotherapeutic schools, suggesting that, in clinical practice, the boundaries between therapeutic modalities may often be indistinct (Hawkins & Nestoros, 1997; Lambert, 1992; Lampropoulos, Spengler, Dixon, & Nicholas, 2002; Norcross & Goldfried, 2005).

Within this integrative contemporary framework, psychodynamic psychotherapy makes a unique contribution to the clinical field in its emphasis on the fundamental importance of the dynamic unconscious, and the potential psychotherapeutic effect of gaining insight into unconscious processes (Eagle, 1987; Epstein, 1994; Freud, 1961d; Shedler, 2010). Indeed, this research project evaluates

the possibility that a clinical focus on unconscious factors may be one of psychodynamic psychotherapy's core contributions to the field of sexual therapy. The dynamic unconscious both contains and exceeds the everyday concept of the unconscious, the latter being a catch-all category inclusive of all elements in the mind that the individual is unaware of at any given moment. The psychoanalytic unconscious implicates psychological processes, including resistance and repression. It is asserted that there are psychological elements (desires, feelings, impulses, etc.), which are essentially unacceptable to us—as they are too threatening to our sense of self—that we relegate to the unconscious in order to safeguard ourselves (Bateman et al., 2010; Gabbard, 2005; Jacobs, 2010). This research explores the hypotheses that: 1) such unconscious factors are significant elements in clients' psychosexuality, that 2) psychosexual symptoms may significantly implicate unconscious elements, that 3) unconscious processes can powerfully affect the client's sexual relationships, and that 4) psychodynamic techniques, intended to foster the kind of self-knowledge Bateman and colleagues (2010) emphasize, may consequently be of utility for psychosexual therapy.[2]

1.2.1. Research Aims and Study Design

The principal research question underlying this work is: *to what extent do psychosexual therapy specialists currently employ psychodynamic therapy techniques in treating men's sexual dysfunctions*? Thus, the primary aim of this research project is to identify the role of psychodynamic methods in sex therapy including their presence, either implicit or explicit, in theory and practice, and the ways in which psychodynamic concepts and techniques may be usefully integrated into the treatment field in the treatment of male sexual problems specifically.

This research project also has a number of explicit *secondary aims*. First, it must be stated that this study is self-consciously situated within the context of an expansive history of treatment for men's sexual problems, and a consideration of this historical context is deemed vital for understanding the empirical underpinnings of

[2] It is, however, essential to note that the assumed importance of unconscious factors, and the consonant value of psychodynamic methods, is not assumed to mandate a traditional or classical psychoanalytic approach (the efficacy of traditional psychoanalysis in treating sexual problems is beyond the scope of this research project). Prior research indicates that unconscious psychological factors do not need to be engaged through a full, traditional psychoanalysis in order for positive treatment outcomes to be attained, and that psychodynamic methods can be effectively used conjunctively, alongside other methodologies, in a wide range of psychotherapy systems, including integrative models (Gold & Stricker, 2001; Kazdin, 1984; Strieker, 1996; Westen, 1998).

contemporary practice. In order to understand the current state of the science (where the field currently stands), therefore, this project aims to clarify the significant historical developments in the field (how we got here). Consequently, this dissertation clarifies both the historical context (secondary aim A) and current context (secondary aim B) of treatment practice, with particular attention to the emphasis that is currently placed on primary treatment frameworks, including biomedical and integrative biopsychosocial healthcare models.

Another aim of this project is to generate data on the use of integrative practices in sex therapy (secondary aim C). Recent research suggests that integration is increasingly considered a fundamental practice in sexual healthcare (Berry & Berry, 2014). Consequently, in order to understand how psychodynamic psychotherapy methods are used by psychosexual therapists, it may be essential to evaluate their application in relation to integrative clinical practice methods. Specifically, this project seeks to clarify how psychosexual therapy specialists conceive of, and utilize, the biopsychosocial model in their work, how they integrate psychotherapy modalities in general, and psychodynamic methods specifically, and how they integrate the partner relationship in the treatment process.

In order to understand how clinicians treat sexual problems within an integrative, biopsychosocial framework, it is also necessary to understand how clinicians understand, assess, and diagnose sexual problems (secondary aim D). How do clinicians use diagnostic models? What are the prevalent diagnostic practices in men's sexual health? How do psychodynamic theories and techniques fit within these practices? This study aims to determine how psychosexual therapists assess and diagnose men's sexual difficulties, and how psychodynamic methods fit within these diagnostic and assessment processes.

In evaluating how clinicians assess and diagnose clinical problems, we may gain insight into the ways in which sexual problems, and their 'solutions', are defined; the next aim of this research project is to determine how successful treatment outcomes are conceptualized in clinical practice. Here, the study aims to clarify the ways in which psychosexual therapists work to establish clinical goals and develop case formulations in their work with male clients (secondary aim E). With respect to goal setting and case formulation, this survey also seeks to answer a crucial question: how do clinicians work with sexual diversity and non-normative client groups? (Secondary aim F). In this respect, this research aims to illustrate the ways in which clinicians work to conceptualize clinical problems and therapeutic

goals in light of the extraordinary diversity of the client populations they work with, and the uniqueness of the clients they serve, as well as the techniques they use with these client groups.

Finally, in light of the aforementioned goals—to illuminate clinicians' understandings of how sexual problems, and their prospective solutions, are defined—the study also aims to uncover psychosexual therapists' understandings of *why* clients' have sexual problems in the first place (secondary aim G). What aetiological factors are seen as prevalent in sexual dysfunction cases? Do clinicians deem an understanding of these factors (i.e. insight into aetiological process) to be a vehicle for therapeutic change, or an otherwise important part of the therapeutic process? How may psychodynamic elements—for instance unconscious factors, or early life variables—continue to exert a detrimental influence on clients' sexual functioning? A crucial secondary aim of this research project is to generate data on sex therapy experts' understandings of the aetiological factors underlying men's sexual problems, including unconscious, developmental, and other psychodynamic elements.

To evaluate the primary research question, and address the secondary research aims, this project used a survey-based research design, which includes both qualitative and quantitative methodologies. From January 2011-June 2013, data were gathered on the clinical practices that specialist sex therapy professionals and generalist psychotherapists use in the psychotherapeutic treatment of male sexual dysfunction. As stated above, a two-part survey—comprised of a quantitative questionnaire, and a qualitative, interview-based survey—was used to identify the self-reported methodologies utilized by these professional populations. The research goal was to assess the prevalence of prototypical and distinctive psychodynamic and cognitive behavioural techniques, and to generate data in the key areas of focus identified here (a comprehensive description of the research design used in this project is provided in chapter 4 of this dissertation).

1.2.2. Overview of Sections and Chapters

This thesis first addresses the secondary aims of the research project (chapters 1-8), in order to provide context for the discussion of the primary research question (chapters 9-10). Section 1 of this dissertation, which includes chapters 1, 2 and 3, outlines the treatment context of male sexual dysfunction, describing historical trends (chapter 2), recent developments and the current state of the science in the

psychotherapeutic treatment of male sexual dysfunction (chapter 3). The aim of this section is to situate this research project within the research field, and contextualize the contribution this study makes to the wider treatment area.

Chapter 2 addresses secondary research aim A, showing how this work is situated within the lengthy history of treatment for male sexual problems by illustrating some of the key historical developments in their treatment, and showing how the scientific field has influenced the development of psychotherapeutic treatments for male sexual dysfunction. Beginning with the ancient Greeks and Romans, this chapter describes a number of essential historical shifts in the treatment field, and illustrates how we have reached our current understanding of male sexuality and sexual problems. The chapter proceeds to describe the rise of the Western[3] medical science paradigm, which includes the emergence of new physiological and psychological accounts of sexual problems. To illustrate the evolution of recent historical thought, this chapter explores the works of several influential thinkers, outlining how their work contributed to current psychological accounts of men's sexual difficulties. The chapter describes the contributions of Richard von Krafft-Ebing, Havelock Ellis, and Sigmund Freud, each of whom acknowledged the importance of psychological factors in sexual functioning, with Freud's work contributing to a primarily psychoanalytic view of psychosexual therapy in the early 1900s. The work of Alfred Kinsey, whose scientific approach helped to shift the focus towards observational study of human sexual behaviour, is then discussed. Finally, some of the main contributions of William Masters and Virginia Johnson, the principal pioneers of modern mainstream sex therapy, are outlined.

A related aim of this research project, identified above (secondary research aim B), is to clarify the current research context, including the role of the biopsychosocial model in contemporary sex therapy practice; in order meet this aim, chapter 3 expands on the historical overview offered in chapter 2, describing recent and current research. A discussion of the current influence of biomedical interventions, and the challenges this influence presents for psychotherapeutic and integrative approaches to sex therapy, is provided. After addressing the role of

[3] Throughout this dissertation the terms "Western", "Western culture", and "Western society" are used to designate the socio-cultural context of Western Europe, and North America—the primary sites of study for this project. Though a sociolinguistic analysis of this terminology is beyond the scope of this dissertation, the reader is advised that these terms are used here to describe overarching social/cultural trends, which are neither universal nor uncontested even within these geographic regions.

recent medical advances, especially developments in the pharmaceutical field, the chapter proceeds to outline some of the recent developments in psychotherapeutic sex therapy, including the significant emphasis placed on integrative practice. The chapter provides a detailed discussion of the biopsychosocial model, in order to highlight the importance of integrative practice in sexual health treatment and provide conceptual grounding for data presented in later chapters (see chapter 5 in particular).

Section 2 of this dissertation, which includes chapters 4-10, presents the research methodology and findings of the project; chapter 4 describes the research methodology used. First, the chapter provides an outline of the research objectives and clarifies the justification for this work, describing the original contribution the research aims to make. The primary and secondary research questions and aims of this project are then elaborated. The chapter proceeds to discuss the development and execution of the two-part survey, before discussing the quality of the evidence, the sampling method, and data analysis/reporting methods used. One important area discussed in chapter 4 is the risk of researcher bias and the strategies used to control for this risk throughout the project. Finally, chapter 4 describes relevant ethical issues, including institutional ethics approval, assessment of risk, use of informed and voluntary consent, and steps taken to safeguard the anonymity and confidentiality of both research participants and their clients/patients.

Chapter 5 addresses secondary research aim C, by presenting quantitative data on the extent to which psychosexual therapists report using the biopsychosocial model, and qualitative data on the strategies they report using for biopsychosocial integration in clinical practice. The chapter begins by outlining how the biopsychosocial model is conceptualized in the sex therapy field. A number of areas for integration are identified, including: the integration of medical and psychosocial (esp. psychotherapeutic) interventions, the integration of psychotherapy modalities, and the integration of psychodynamic and CBT techniques. The chapter then presents data on another area of integration identified as crucial in this study and in the wider literature: the integration of the partner into the biopsychosocial treatment of male sexual dysfunction (Leiblum, 2007b). The primary aim of chapter 5 is to present the data on the grounding principles—biopsychosocial and integrative practice—within which psychodynamic methods are evaluated in this study.

Chapter 6 evaluates the ways in which clinicians understand, assess, and diagnose sexual problems, addressing secondary research aim D. It presents data on

the ways in which psychosexual therapists conceive of, and use (or refrain from using) diagnostic categories in their work. The purpose of this chapter is to clarify research participants' self-reported assessment practices, illustrating both best practices and controversies in diagnosis. The chapter illustrates the debates around diagnostic practice evident in the data, describing research participants' views on conventional psychodiagnostic categories, which often appear to be highly critical. The qualitative and quantitative data on the methods and techniques sex therapists use in assessing clients' sexual problems are described. In considering the data on assessment practice, the chapter aims to clarify the role of psychodynamic *insight* as both an assessment objective (i.e. the therapist's insight into possible unconscious factors in the client's sexual difficulty), and a treatment goal (i.e. the client's own increased insight into aetiological factors in the sexual problem). Consideration is also given to data on the high level of importance placed on assessing early life and developmental factors as potential contributing elements in the client's sexual problems. This discussion offers a point of departure for understanding how psychodynamic insight may be emphasized in the early phases of psychosexual therapy.

Chapter 7 further elaborates on the role of psychodynamic methods in the early stages of sex therapy, addressing secondary research aim E by presenting data on the process of goal setting and case formulation, and on strategies that may be used when working critically with non-normative client groups. The chapter presents data on practices that are prevalent in goal setting and case formulation, how these practices are influenced by psychodynamic principles, and how they account for client diversity, subjectivity and uniqueness. First described is the dominant, client-led, subjective goal setting structure, apparent in the data. Then, the processes of negotiation that clinicians report using as they work to set realistic therapy goals are outlined. Data on the use of a sexual model that emphasizes pleasure, desire and intimacy (rather than a performance based model) are described. Chapter 7 then proceeds to address secondary research aim F, by identifying the specific challenges of working with diverse and non-normative clients, which are apparent in the data, a crucial consideration in the field of sex therapy (Barker, 2011a; Barker & Langdridge, 2010b). Published research indicates that clients who fall outside the heteronormative and mono-normative framework—including lesbian, gay, bisexual,

trans and queer (LGBTQ) clients, clients involved in the BDSM[4] community, and openly non-monogamous clients—are under-examined in the research field. Some of the challenges and key strategies in working with these non-normative client populations, apparent in the qualitative and quantitative data in this study, are highlighted. The chapter presents evidence that a critical sex therapy orientation, which uses social constructionism to foster reflective practice and to support or affirm diverse client identities, may be particularly useful. A number of key critical sex therapy techniques identified by research participants are described.

Chapter 8 explores a central question: why—in the view of experienced clinicians—do clients experience sexual problems? To further evaluate how psychodynamic insight may be an important component of the clinical process, the chapter addresses secondary research aim G, outlining some of the aetiological factors that survey participants identify as particularly significant. Here, specific attention is devoted to the role of psychodynamic aetiological factors that are considered prevalent in sex therapy cases. The chapter examines the qualitative and quantitative data on clinicians' perceptions of the causal role of early life experiences, and the influence that relationship models and attachment patterns, developed in infancy and childhood, may have on the client's sexuality and sexual functioning in adulthood. A number of salient themes in the data, pertaining to the role of developmental factors in the client's sexual dysfunction, are addressed. The chapter then presents data on the perceived aetiological contributions of a number of prominent cognitive and affective tendencies including anxiety, guilt, and shame, which are thought to have significant roots in early life experiences. The chapter discusses these factors with attention to the unconscious elements they may implicate, and the role that physical embodiment may play in the manifestation of these psychoaffective processes. Lastly, chapter 8 describes the ways in which mentalization-based theory may be used to interpret aetiological factors, before highlighting a psychodynamically-informed practice evident in the research data: clinicians' emphasis on discovering the unconscious meaning or function of the sexual symptom as a foundation for therapeutic change.

Chapter 9 addresses the primary research question. The aim of this chapter is to present data on the principal hypothesis of this research: that sex therapists commonly use psychodynamic techniques in their work with male sex therapy

[4] BDSM is defined here as both a set of sexual practices, and a set of sub-cultural identities involving bondage and discipline, dominance and submission, sadism and masochism.

clients. To this end, the chapter reports and discusses the quantitative and qualitative data on sex therapists' and psychotherapy generalists' self-reported use of prototypical and distinctive psychodynamic and cognitive behavioural techniques. Here, the psychodynamic concepts that appear to be most important in the treatment of male sexual dysfunction, according to the data collected in this research project, are highlighted. First, the quantitative data on clinicians' use of psychodynamic and CBT techniques are presented. To clarify the discordance between these results and the wider research field (in which, as stated above, attention to the psychodynamic practices in sex therapy appears to be extremely scarce), the distinction between implicit and explicit use of psychodynamic techniques in the treatment of male sexual dysfunction is discussed. Chapter 9 then proceeds to evaluate the qualitative data on the role of two key psychodynamically-informed frameworks: 1) attention to the role of the unconscious in sexual problems and their treatment, and 2) emphasis on a developmental, relational perspective on sexual relationships and sexual problems (as well as their resolution through psychotherapy). The chapter concludes by evaluating the prominence of attachment theory within the data, and discussing mentalization-based therapy, which is identified as a potentially fruitful avenue for further research and integration within the treatment of sexual disorders.

This dissertation concludes, in chapter 10, with a summary discussion, which aims to highlight the significance and uniqueness of this work within the research field. First, the chapter provides a synopsis of the key findings of this research project. The chapter then considers the implications of the research for other researchers, for clinicians, and for the wider population, including sex therapy clients. Limitations of the survey are then outlined. The dissertation concludes by describing how this research can be built on in the future, and how it can be translated into further research initiatives.

1.2.3. Note on Language and Terminology

Throughout this dissertation inclusive language is used, with respect to gender. The pronoun "they" has often been used in favour of s/he, to ensure inclusion of individuals who do not identify within the context of binary gender categories. Such use of the epicene "they," as both a singular and plural pronoun, has clear precedent in sociolinguistics (Balhorn, 2004; Barnowski, 2002). At a number of points, the masculine pronoun "he" is also used, to describe work with male clients specifically, as this research focuses on clinicians' experiences with a

male client population in particular.

Additionally, the terms "sexual dysfunction" and "sexual disorder" are used throughout the dissertation, following the diagnostic model of the *Diagnostic and Statistical Manual of Mental Disorders IV-TR*, and the *Diagnostic and Statistical Manual of Mental Disorders 5* (American Psychiatric Association, 2001; American Psychiatric Association, 2013). The reader is advised, however, that a number of sex researchers have critiqued mainstream psychodiagnostic terminology—including the terms "sexual dysfunction" and "sexual disorder"—and the underlying diagnostic system, emphasizing that uncritical application of standardized diagnostic categories may serve to incorrectly pathologize or stigmatize certain sexual behaviours and identities (Barker, 2011a; Berry & Barker, forthcoming 2015; Kleinplatz, 2012b). This debate about diagnostics and terminology is addressed at length in chapter 6, and it bears mention that this research aims to maintain a critical view that acknowledges the complexity of diagnostic categories and practices, and esteems the dignity and uniqueness of the client.

Some clinicians advocate the use of "sexual problem" in lieu of "sexual dysfunction", and throughout this dissertation the term "sexual dysfunction" is used interchangeably with the terms "sexual problem", "sexual difficulty" etc. The reader is advised that within this research project, sexual dysfunction is conceived of as a fluid category that reflects the unique, variable and subjective experience of each individual, rather than a fixed category of pathology/abnormality. As indicated in the discussion of terminology in chapter 6, specific diagnoses are seen to reflect common symptomatologies (for instance, erectile or ejaculatory problems) within the wider frame of the individual client's lived experience.

CHAPTER 2. HISTORY OF SEX THERAPY FOR MEN'S SEXUAL PROBLEMS

It is important to ask—how did we get here? What trajectory of thought and science has brought us to our current integrative, biopsychosocial model of sexual healthcare? To understand the current significance of sexuality and sexual functioning, and thereby to comprehend their clinical importance for healthcare providers, it is beneficial to evaluate how these aspects of human experience have been construed throughout history. This chapter illustrates that the valuation of male

sexual performance is—perhaps unsurprisingly—not merely a characteristic of contemporary discourse on masculine identity, but rather a pervasive priority in the history of our culture. However, the contemporary logic of treatment, which emphasizes particular medical and psychotherapeutic interventions within the context of a biopsychosocial treatment model, is culturally specific. To shed light on the reasoning that underlies current sexual therapies, chapter 2 traces essential historical developments with respect to male sexuality and the evolution of treatment for male sexual problems. First, ancient practices are considered, then more recent developments are discussed, in relation to the contemporary biopsychosocial treatment model.

2.1. The Importance of Male Sexual Capacity Throughout History

Research suggests that male 'potency' is amongst the most powerful and pervasive human values (McLaren, 2007). While its meanings, and the narratives surrounding it, have evolved through human history, the simple and insuperable priority of male sexual prowess is apparent across cultures, throughout history. Yet, masterful sexual performance cannot be taken as a universal human fact. Failings of the flesh abound. Ovid, in *The Amores*, timelessly laments:

> And it's not that she wasn't seductive, just think of those
> marvellous
> Kisses she wasted on me, the tricks she tried!
> She could have shifted an oak-tree, broken hard adamant,
> Worked up unfeeling stones:
> A living, virile partner, for her, was a pushover—but just then
> I lacked both virility and life.
> What joy can a blind man get from a painted picture?
> What's the use of a singer performing for the deaf?
> I imagined every variety of erotic pleasure, invented
> No end of positions—in my head—
> But still my member lay there, an embarrassing case of
> Premature death, and limper than yesterday's rose.
>
> (Ovid, *The Amores*, 3:7, p. 151)

In the presence of appropriate stimuli, and despite the absence of an identifiable deterrent, the body sometimes fails to respond as desired. From this simple event, a history of scientific (and, at times, pseudo-scientific) inquiry has emerged.

The importance accorded to sexual functioning by so many men, and the distressing reality of sexual dysfunction, have yielded a timeless demand for curative therapies. In instances of sexual dysfunction, under the assumption that something incomparably important has broken, men have sought a fix. Predictably, opportunists have eagerly taken advantage of men's desperation and willingness to pay for a solution to the problem of sexual dysfunction, offering a variety of pills and potions with grand restorative claims—for a not-inconsiderable price—through the ages. Scrupulous scientists and researchers, however, have been equally concerned with men's sexual problems, and have sought to discover, or develop, legitimate cures. Worthy medicaments, though, have often proved elusive. The herbological and magical cures employed by ancient civilizations were, by contemporary scientific standards, of dubious value (Taberner, 1985), and more recent historical developments have also been besought by the limitations of knowledge and science (McLaren, 2007). Only recently have we succeeded in developing scientifically methodical and empirically verifiable treatments for men's sexual dysfunctions (Waldinger, 2008).

2.2. History and Evolution of the Treatment of Male Sexual Dysfunction

Treatments and nostrums for male sexual problems predate recorded history, and throughout the annals of human knowledge there are myriad medicines and methods intended to insure, or restore, male potency. These treatments are, varyingly, rational or mystical, distasteful or pleasing, innocuous or dangerous. They show marked similarity in both intent and formulation across cultures and across time, underscoring the importance of sexual performance and male 'potency'. Though the meanings of sexuality, and the forms of socially sanctioned sexual behaviour, vary markedly both between and within cultures, the specific demand for sexual cures may be a near-universal cultural phenomenon. The priority of effective sexual therapy certainly is an enduring aspect of Western culture. Historical evidence, both recent and ancient, suggests the urgent desire for effective therapy can foster a willingness to try nearly anything, from arcane herbal remedies, to mystical incantations, to visceral interventions. Today, the demand for effective sexual therapy is patently apparent in the development of new treatments and the aggressive

marketing and robust sales of new 'cures,' both validated (i.e. Viagra) and spurious (any of the innumerable miracle cures marketed online, for instance).

2.3.1. Ancient History

For many ancient medical writers, impotence "was an illness to be cured" (Rider, 2006, p. 21). This therapeutic approach parallels mainstream contemporary conceptions of sexuality, which routinely categorize sex and sexual functioning in binary terms, with respect to health and pathology, normalcy and abnormality. Yet, beyond this implicit distinction between health and illness, ancient conceptualizations of sickness varied significantly from current standards. Ancient cultures in their willingness to accept metaphysical explanations of physical phenomena were much more amenable to spiritual and mystical explanations for physical ailments, including sexual dysfunctions (Taberner, 1985). By extension, they tended to readily accept metaphysical and magical cures and treatments. In addition to metaphysical causes, ancient cultures accounted for sexual dysfunction in physical and biological terms, attributing sexual problems to physical exhaustion, infirmity, and old age (Bhugra & de Silva, 1995; McLaren, 2007; Taberner, 1985). The latter attributions more closely resemble contemporary medical concepts of biological pathogenesis. Largely absent from ancient history's account, however, was a critical conception of psychogenesis. Whereas we now have the biopsychosocial model—a tripartite causal and curative system encompassing the biological, psychological and social—it appears that ancient civilizations often employed a dualist system that included biological causes and extrinsic natural causes. In short, for the ancients, male sexual dysfunction was often viewed as an illness caused by either external forces, or physiological failings.

2.3.2. Herbology: Ancient Greek and Roman Cures

Ancient Greek and Roman cultures are amongst the most widely cited amongst ancient civilizations with respect to medicine. They were systematic in both treating dysfunctions—through a vast range of herbological cures—and in documenting treatment methodologies encyclopedically. In this respect, though the knowledge of the day differed drastically from our own, the Greek system of methodical treatment and meticulous documentation paralleled the methodical aspect of our own health sciences paradigm. Dioscorides, an ancient Greek physician whose five volume *De Materia Medica* strongly influenced Western pharmacopoeia

through until the sixteenth and seventeenth centuries, addressed sexuality and aphrodisia, prescribing a range of cures for sexual dysfunction (Dioscorides, 2005/Orig. 1st Century CE; Riddle, 1985). Pliny the Elder, a Roman philosopher working contemporaneously with Dioscorides, produced a *Natural History* that inventoried much of the period's knowledge, including the most comprehensive catalogue of sexual enhancers and remedies known to that time (Doody, 2009; Secundus, 1857/Orig. 1st Century CE; Taberner, 1985). Interestingly, ancient Greeks' and Romans' manifest tendency to carefully document medical knowledge resembles our era's development of diagnostic and treatment manuals, and the works of both Pliny and Dioscorides present these cultures' accepted first line of defence against sexual ailments—herbology.

McLaren indicates the significance of sexual dysfunctions and their cures for the ancient Greeks and Romans, emphasizing, "the sheer volume of material devoted to the discussions of how impotence could be cured" (2007: 13). Summarizing the conventional prognostics in ancient Greece and Rome, he writes, "to judge by the literature, men's most common response to fears of impotency was to consume an inciting herb or beverage" (Ibid. 15), additionally, "to protect himself against impotence a man might wear a stone talisman or amulet...and finally one could make an appeal to the gods" (Ibid. 19). This line of reasoning reflects ancient cultures' common tendency to view sexual dysfunctions' aetiologies as physiological and/or metaphysical, and to structure treatments accordingly. In comparing these tendencies to our milieu, it is easy to see the parallel between the use of "inciting herb[s] and beverage[s]" and the use of pharmaceutical treatments. Though there is limited contemporary evidence on the therapeutic use of prayer or metaphysical charms in treating men's sexual dysfunctions, it seems reasonable to surmise that these methods may have had an important psychological effect—a key consideration in modern sex therapy.[5]

Greek and Roman medical knowledge, historians suggest, was preserved by Arab cultures and revived in the Western world in the Middle Ages and during the enlightenment (Orfanos, 2007). Consequently, many ancient medical techniques were revived in the Medieval era and, increasingly, tied to Christian theological and epistemic systems. Constantine the African compiled the first fully comprehensive medical text in Latin, the *Pantegni*, circa 1000 (Burnett & Jacquart, 1994). The

[5] It also seems likely that contemporary sexuality has its own elements of ritualism, and perhaps even appeals to the supernatural—interesting sociological and anthropological facets of contemporary society that would be fruitful grounds for future research.

information captured in the *Pantegni* reveals the trajectory of knowledge from the ancient world onwards. "These writings of Constantine," Singer writes, "were, for the most part, mere translations, very badly rendered, from the Arabic of the Egyptian Israelite…Isaac Judaeus (died A.D. 932 or 941)" (Singer, 1917, p. 1). In turn, Judaeus' work was cribbed from Greek physician Galen (circa 199 C.E.), making Constantine's *Pantegni* an important conduit by which Greek and Arab medical knowledge was transferred into the Western world during the Middle Ages.

As with older societies, in Europe during the Middle Ages healers and lay people alike often acknowledged a variety of physiological and spiritual causes for the sexual dysfunctions, and a comparable range of cures, rooted in magic and herbology. For them, it is reported, sexual dysfunction (cast as "impotence") was the physical ailment for which men most frequently sought magical assistance (Roper, 1994). Medieval scholars and physicians, "began with what they called 'natural impotence,' *impotentia naturalis*. This kind of impotence had an inborn, physical cause…opposed to this was 'accidental impotence,' *impotentia accidentalis*, which was inflicted on a person later in life" (Rider, 2006, p. 8).[6] These categories of impotence bear a noteworthy resemblance to contemporary diagnostic standards—as defined in the *Diagnostic Standards Manual (TR-IV, and 5)*—which classify the sexual dysfunctions as primary (lifelong) or secondary (acquired). In these Medieval classifications, then, we see a nascent tendency to subdivide, or specify unique pathological types, in order to achieve differential diagnoses, the same principles that govern contemporary psychiatric diagnostic methods. Despite this resemblance, the reasoning underlying medieval therapy was very different from contemporary healthcare.

Medieval cures, Rider writes, "might rely on natural causes (however the writer defined these)…or on the power of God" within the spiritual and theological systems of the time (2006, p. 10). "Natural causes" were not equated solely with the physical world, but were also seen to encompass the metaphysical world, legitimating magical remedies. Consequently, in the Middle Ages a variety of curative means were used to address sexual dysfunction, including spiritually imbued

[6] The latter phenomenon was routinely attributed to a culturally specific, and specifically gendered, concept: witchcraft (Rider, 2006; Sigerist, 1943). In the *Malleus Malleficarum* (1487), the Dominican inquisitor Heinrich Kramer alleged that witches interfered with marriage through "impotence *maleficarium*"—ultimately the work of the devil, who could impede marital relations "by interposing himself as a phantom lover, by freezing a man's desire, by making the woman appear loathsome to him, by directly preventing the erection, and finally by closing the seminary ducts so ejaculation could not take place" (Krämer, 1971/Trans. 1928, Orig. 1487). Notably, this demonological explanation can reasonably be seen to cover a range of male sexual dysfunctions, as contemporarily defined.

herbology, 'natural magic,' and Church sacraments[7] (McLaren, 2007, p. 45). In the contemporary era, much healthcare research has been focused on developing, and marketing, a scientifically-derived and empirically validated 'magic bullet' to cure sexual dysfunction[8]; by contrast healers and patients in the Middle ages were happy to pursue metaphysical magical cures. Whereas we seem to search for a proverbial 'magic' cure, Medieval culture sought recourse to actual magic, and the logic of magic in the Middle ages resembled and extended the logic of magic from earlier periods.

2.3.3. Magical Cures

According to Frazer, in his influential treatise, *The Golden Bough*, magical cures adhered to two fundamental laws: the Law of Similarity ("that an effect resembles its cause") and the Law of Contact ("that things which have once been in contact with each other continue to act on each other at a distance") (1942, p. 11). In herbology, in both ancient and Medieval cultures, the law of similarity was regularly construed as the 'doctrine of signatures,' under the premise that God, or the gods, had inscribed elements in nature with their intended purpose; this principle indicated the use of a range of herbs, as well as the generative organs of animals, in treating sexual problems (McLaren, 2007, p. 17; Taberner, 1985, p. 56). The Law of Contact was the foundation for explaining both spiritual causes of sexual difficulties (i.e. in the premise that a man could come in contact with something that would contaminate or corrupt his sexuality and compromise his potency), and the logic underlying charms and philters used to treat sexual dysfunctions.

Of the three sexual treatments used most widely across cultures, two—the rhinoceros horn and the mandrake root—are explicable by the Law of Similarity (Taberner, 1985, pp. 99-120). Neither has a biological basis, aside from nominal nutrient/vitamin content that, for individuals with dietary deficits, could have provided a slight overall health benefit. The mandrake root was widely prescribed, either for ingestion or for use in amulet form, for a vast range of physical diseases and complaints, as it was imputed to resemble either a penis, or the entire form of a

[7] Alternatively, in cases of "impotence *maleficarium,"* one could kill the witch deemed responsible, or force her to end the spell.

[8] It must be noted that, despite the trend towards empirically and scientifically validated medicines, there is still a significant market for unproven, illegitimate and often dangerous lay cures and traditional shamanic remedies. The psychology underlying men's amenability to spurious cures (and the broad willingness to try remedies that may in fact be detrimental) is an interesting and worthwhile direction of inquiry for further research.

man (hence its alleged usefulness as a panacea). Rhinoceros horn, whose phallic resemblance is unmistakable, was also seen as a cure-all and a potent aphrodisiac, with the ability to restore sexual health and vitality. Considered in relation to the biopsychosocial model, it may be reasonable to speculate that such 'magical' cures operated (and still operate) largely through a placebo effect, catalyzing improvement through the psychology of suggestion. As such, these cures—and effectively any cure that the patient has faith in—could have a real, but likely inconsistent, psychotherapeutic effect.

Spanish flies, the other most widely used sexual treatment, are amongst the most well known sexual stimulants in history. 'Spanish fly' is a vernacular term for cantharides, or blister beetles. The active component, cantharidin, is a potent poison (32 mg is a potentially lethal dose), and its effect is likely the source of Spanish fly's reputation. Cantharidin is a severe irritant and when ingested orally elicits sensations of physical agitation, particularly fever and irritation of the digestive and urinary tracts, which could be misconstrued as signifying physiological and sensual arousal. The same physical function probably underlies the use of a wide variety of poisons that have been used as sexual stimulants. Spanish flies, and other sexual stimulants with perceptible physiological side effects likely have the same psychotherapeutic placebo effect as Rhinoceros horn and mandrake root may have, with the added impact of evident physiological consequences.

The contemporary 'magic bullet,' Viagra (and analogs in the phosphodiesterase-5 inhibitor family), has a fundamentally different scientific basis from historical lay cures. It has an empirically verified physiological effect.[9] However, while their scientific foundation differentiates phosphodiesterase-5 inhibitors (PDE5is) from the lay treatments found throughout history, their use may reflect the same desire and medicative principles. It appears that the PDE5is are often conceptualized, and marketed, as a contemporary 'magic bullet'—through simple ingestion, it is suggested, these drugs will resolve sexual dysfunction. However, the biopsychosocial model suggests that a reductively biomedical approach may be inadequate for many patients, and may not address the important relationship dimensions of sexual problems (McCarthy & McDonald, 2009a). We can, therefore, derive an important clinical lesson from historical comparison—the biopsychosocial model specifies that healthcare providers must not overemphasize

[9] A brief overview of the pharmacodynamics of the phosphodiesterase-5 inhibitors is provided in chapter 3.

the biological facets of sexual dysfunction to the exclusion of psychological and social factors. In fact, to a certain degree, the benefit derived from drug therapy may also operate through psychological means (i.e. the placebo effect). Modern healthcare has developed a sophisticated, critical awareness of the psychosocial elements of sexual dysfunction, and a biopsychosocial treatment approach. As we will see, however, the risk of overstating the physiology of sexual dysfunctions, and underemphasize their psychological and social aspects, is still considered a significant problem in sexual medicine.

2.4.1. Sex and Rational Inquiry: The Precursors of Sexual Medicine

Although ineffective and dangerous sexual treatments continue to be used and aggressively marketed (one need look no further than the internet to uncover a plethora of scientifically unfounded sexual enhancers), a significant, though gradual, epistemological and methodological shift transpired through the seventeenth and eighteenth centuries, paving the way for current medical and scientific models. This evolution can be seen as a clear contributor to the development of the biopsychosocial model. "During the 1600s and up until the late 1800s," Atwood and Klucinec write,

> with the rise of the medical professions, physicians became an increasingly important secular source of values, beliefs, education and guidance (i.e., often prescriptive of how to behave sexually and otherwise)…This shift in emphasis from religious bases to one of a matter of health and disease carried its own classification, organization, and propriety (2007, p. 59).

This development saw the gradual emergence of psychogenesis as an acknowledged aetiology for sexual dysfunctions.

> "Michel de Montaigne," McLaren writes,
> produced the most famous sixteenth-century discussion of the power of the imagination to both cause and cure impotence…[writing] 'I am moreover of the opinion that those ridiculous attacks of magic impotence by which our society believes itself to be so beset that we talk of nothing else can readily be thought of as resulting from the impress of fear or apprehension' (McLaren, 2007, p. 49; Montaigne, 1991/Orig. 16th Century CE).

In the Arab world, Cheikh Nefzaoui also acknowledged the psychogenic bases for sexual dysfunction. In his renowned 16th century[10] treatise on sexuality, *The Perfumed Garden*, he proclaimed that sexual dysfunction could, under certain circumstances, be the result of "an exaggerated respect for the woman…a misplaced bashfulness…because one has observed something disagreeable, or on account of an unpleasant odour; [or] finally, owing to a feeling of jealousy, inspired by the thought that the woman is no longer a virgin" (Nefzaoui, 1886/Orig. 16th Century CE, p. 201). These works offer some of the first documented, explicit acknowledgement of the psychological and social aspects of the biopsychosocial system.

In England, surgeon John Marten's 1709 book, *Gynosologium Novum; or A new System of All the Secret Infirmities and Diseases, Natural, Accidental, and Venereal in Men and Women*, reflected a crucial shift towards both the medical and psychological models of sexual dysfunction. In this work, Marten framed the psychological dimension of sexual dysfunction as a key component of the disease aetiology; likewise, he advocated a scientifically-founded, methodical medical treatment. For Marten, a significant proportion of sexual dysfunction could be explained physiologically, and his work anticipated insights of modern urology, including the association between obesity and sexual dysfunction, and the connection between smoking and sexual dysfunction (Marten, 1709). Marten's work was also significant for its rejection of witchery as a cause of sexual dysfunction, and its acknowledgement of the psychogenic foundations of sexual dysfunction. Although he saw physiogenic causes as primary, according to Marten sexual dysfunctions could ensue "when the spirits are depressed by Trouble, Grief, Fear, Passions of the Mind, Hypochondriack Melancholy, over-Thoughtfulness, study, etc." (1709, p. 42). While an early insight into the biopsychosocial schema is evident in Marten's work, the *Gynosologium* was hardly published in the spirit of pure science: Marten used it as a foundation for hawking proprietary aphrodisiacs.

Opportunistic sale of aphrodisiacs and sexual enhancers defines much of the medical and pseudo-medical history of sexual science in the Modern era. As with ancient societies, Modern Western cultures were eager to seek external remedies for the sexual dysfunctions. This propensity paved the way for numerous charlatans to promote fraudulent cures. Spurious "cures" at the turn of the twentieth century were not restricted to quacks and snake-oil salesmen, however. Merck's *Manual of the*

[10] Although the exact date of Nefzaoui's work is not known (it was translated into English in 1886), it may have been written in the 15th Century, though the first translators attributed it as a 16th Century text (Nefzaoui, 1886).

Materia Medica of 1899 included a section dedicated to aphrodisiacs, which had little-to-no empirical basis (Merck, 1899). Thankfully, simultaneously and subsequently to the publication of the 1899 Merck *Manual*, psychiatry and psychology (along with an array of biomedical disciplines) have drastically advanced the field of sexual science.

2.5.1. Recent History

The recent history of sexual therapy seems to trace the back-and-forth arc of a swinging pendulum, and is marked by, perhaps unduly, discrete disciplinary approaches. While the seeds of an integrative biological, psychological and sociological treatment approach are apparent, recent history has apparently tended towards an 'either-or' stance, privileging single aspects of this model, and failing to develop a stable, balanced system. This trend may be crucial in understanding the state of contemporary sexual healthcare, which may be beset by the same type of challenge, in the form of a binary approach that divides between medical and psychotherapeutic treatment avenues.

Generally, through the eighteenth and nineteenth centuries the medical establishment claimed authority over sexuality and the treatment of sexual issues, adhering to primarily physiological models of treatment (Atwood & Klucinec, 2007; Oosterhuis, 2000). However, research suggests that through the latter portion of the 1800s, psychiatry began to take control of the sex therapy field, reflecting both psychiatry's emergence as a discipline, and a growing psychologically-oriented understanding of sex (Oosterhuis, 2000). According to Waldinger, the period between the 1880s and 1930s can be classified as the first definitive era in the history of sexology, understood as a proper and distinct field; this period, Waldinger (2008) argues, was a disciplinarily psychiatric era.

Through the better part of the twentieth century, McLaren suggests, sexual therapy was primarily psychological in orientation, under-emphasizing the biological aspects of treatment (2007). Freud's contribution to sexual science during this era was arguably the most influential of the time, orienting the field towards psychogenic explanations of the sexual dysfunctions. Additionally, although psychiatry arguably remained the dominant discipline for the first half of the twentieth century, the field of study began to broaden, with psychologists gaining influence in an increasingly multidisciplinary treatment sphere. This development was a step forward with respect to the acknowledgment of psychosocial aspects of sexual dysfunction. The

'magic bullet' approach was largely displaced, at least within the context of mainstream medicine, and successful therapy outcomes were assumed to be the product of rigorous psychotherapeutic work. However, it appears that this psychological and psychoanalytic trend often translated into an under-emphasis on biological treatment. The psychological aspects of theory and clinical practice during the Modern era warrant close consideration. To contextualize the development of contemporary sex therapy, and the application of the biopsychosocial model, we may consider the crucial contributions of a number of a number of key thinkers, including: Krafft-Ebing, Havelock Ellis, Freud, Kinsey, and Masters and Johnson. It is valuable to examine the works of pioneers before Freud (especially Krafft-Ebing and Ellis) by virtue of their influence, both direct and indirect, over Freud's thinking about sex. This examination serves to both situate Freud's work in its historical context, and illustrate the unique aspects of Freud's thought, and the pronounced ways in which his conceptualization of sexuality departed from prior understandings.

2.5.2. Krafft-Ebing

While biology—specifically the physiology of the brain and nervous system in relation to sexual behaviour—was a keystone of Krafft-Ebing's work, close examination of his celebrated *Psychopathia Sexualis* (Krafft-Ebing, 1901/Orig. 1886), reveals Krafft-Ebing's attention to the psychological aspects of sexual pathology. Though he relied on the idea of physiological (neural and neurological) aetiologies, psychological aspects became important elements in the diagnostic processes he proposed (Hauser, 1994). A psychiatrist by trade, Krafft-Ebing endeavoured to examine sexuality and sexual disorders scientifically and methodically, and although his work focused principally on sexual behaviours and identities that were considered deviant (i.e. paraphilias), his scientific contribution and attention to the psychological underpinnings of sexual proclivities helped to lay the groundwork for subsequent sexual science in general, and the development of the biopsychosocial model.

Krafft-Ebing stressed "the impact of sexuality on human feeling, thinking, and behavior," concepts essential to the psychosocial dimensions of contemporary sex theory and sex therapy (Oosterhuis, 2000, p. 61). In this respect, Krafft-Ebing's work presaged the current biopsychosocial approach to sex therapy, especially more recent cognitive and behavioural developments in the field. *Psychopathia Sexualis*

expressed the conviction that human sexuality was more than a basic corporeal function, or the biologically reductive expression of an instinct. To this effect, Krafft-Ebing

> asserted that the 'unconscious life of the soul' strongly affected the functions of the body…Thus, prior to Freud, psychiatrists had already begun to view human sexuality as distinct from the instinctual sexuality of animals, and they established the idea that sexual disorders could result from unconscious psychological processes (Oosterhuis, 2000, pp. 61-62).[11]

This insight reveals a key conceptual shift in the field of sexual medicine (esp. sexual psychiatry): psychological processes were becoming broadly accepted as causal explanations for sexual problems.

Generally, Krafft-Ebing attributed the phenomena now classified as male sexual dysfunctions to neurasthenia and to cerebral neuroses, which "fall within the domain of psychopathology" (1901/Orig. 1886, pp. 46-47). Although these causal attributions were usually physiologically-oriented, based in the biomechanics of the nervous system, in *Psychopathia Sexualis* Krafft-Ebing clearly acknowledges the psychogenic and psychological aspects of men's sexual dysfunctions. In fact, in Krafft-Ebing's view physiology and psychology were intimately and reciprocally connected in the sexual realm; "since the generative organs," he wrote, "stand in important functional relation to the entire nervous system and especially to its psychical and somatic functions…disturbances [are] easy to understand" (Krafft-Ebing, 1901/1886, p. 44). This represents a notably balanced view of patient sexuality as a biological and psychological process—a perspective that accords well with the biopsychosocial model.

While he offered physiological explanations, such as substance intoxication or a paralytic impairment of the nervous system, for the sexual dysfunctions, Krafft-Ebing also suggested "*inhibition*" as a cause of erectile dysfunction. In some cases, he argued,

> The erection centre may become incapable of function through cerebral influence. This inhibitory influence is an emotional process (disgust, fear of contagion), or fear of impotence. There are men who have an unconquerable antipathy to woman, or fear of infection, or are suffering with perverse sexual instinct. In the latter conditions are those neuropathic individuals…who have

[11] Here Oosterhuis is quoting Krafft-Ebing's 1889 paper "Bemerkungen zur Hypnotischen Heilmethode," published in *Wiener Medizinische Presse*, 30: 1185-87 (Krafft-Ebing, 1889).

> reason, or think they have, to mistrust their sexual power. This idea acts as an inhibitory impulse, and makes the act with the person of the opposite sex temporarily or absolutely impossible (Krafft-Ebing, 1901/Orig. 1886, p. 45).

Similar mechanisms, he stated, could precipitate a neurasthenic development that yielded premature ejaculation. In cases of "enforced abstinence," or a "congenitally irritable" nervous system, "the risk of premature ejaculation increased immensely," and sometimes, he suggested, "simple embraces or caresses, with or without contact of the genitals, are sufficient to induce ejaculation and consequent satisfaction" (Krafft-Ebing, 1901/Orig. 1886, pp. 339-340). Thus, for Krafft-Ebing, 'nervous' tendencies—often in conjunction with masturbation, which Krafft-Ebing deemed widely pathogenic—could cause premature ejaculation or erectile dysfunction. A close reading of his work suggests that Krafft-Ebing's significant contribution to the field of sexual science includes: his scientific and methodical approach to behavioural and identity categories, his integrative acknowledgement of both physiology and psychology, and his concept of the causal relationship between 'neurasthenia' (nervous illness) and sexual problems, theoretical developments that would heavily influence the emergent field of 'sexology' (and, subsequently, sex therapy), and the development of the biopsychosocial framework.

2.5.3. Havelock Ellis

Havelock Ellis ranks amongst the most significant sexual theorists in the Modern period. His major work, *Studies in the Psychology of Sex*, published in seven volumes between 1897-1928 conceived of sexual functioning in terms of both biological and psychological processes (Grosskurth, 1980). Ellis's vehement arguments defending homosexuality, masturbation, and early sexual experience—forms of sexual expression that had been widely demonized in the Victorian era—were highly influential, and anticipated important, and ongoing, shifts in the discourse of sexual science. Thus, Robinson writes, "Ellis's importance for modern sexual theory lies in the pervasive attitude of tolerance and enthusiasm with which he approached human sexuality. In effect, he established the atmosphere, though not the explicit theoretical context, in which later thinkers were to pursue their tasks" (1976, p. 41). As with Krafft-Ebing, Ellis's enduring contribution to the theory and treatment of sexual problems consists in his strong emphasis on scientific method in the field of sexuality, and his methodical, sex-positive approach to psychological inquiry.

Ellis held that sexual desire and performance are inextricably tied to both biology and psychology, and that 'nervous' conditions could readily cause sexual disorders. Either constitutional (i.e. innate dispositional or physiological qualities), or circumstantial (i.e. psychosocial) factors, Ellis posited, could cause sexual dysfunctions, which were seen as exceedingly common (1954, Orig. 1933). Psychosocially, Ellis believed, dysfunctions could be caused by nervous illness and the social factors underlying it. "In civilization," Ellis wrote, "the strenuous demands of life and the more or less unnatural conditions under which the sexual impulse develops combine to produce a frequent inability, relative or absolute, to secure potency in coitus" (1954, Orig. 1933, p. 303). In this respect, his work agreed with Krafft-Ebing, and with Freud, reflecting an understanding of neurasthenia commonly held by psychiatric researchers of the time. Additionally, this perspective may be seen to agree with contemporary biopsychosocial theories on the aetiology of sexual problems (McCabe et al., 2010; Perelman, 2006b; Riley & Riley, 2009). As later chapters in this dissertation indicate, the idea that life's 'strenuous' demands, and the restrictive/'unnatural' conditions of sexual development, are seen by many contemporary sex therapists as important contributing factors in many clients' sexual problems.

For Ellis, performance anxiety, which he describes as a "great nervous terror" (Ellis, 1954, Orig. 1933, p. 305), is a significant causal factor in sexual dysfunction, and "a temporary loss of potency under a high emotional strain may easily occur and is not of any serious import" (Ellis, 1954, Orig. 1933, p. 304). As such, he identifies,

> two classes of cases, those of psychic impotence and those of what may perhaps still be termed neurasthenic impotence. In the former, the mechanism of detumescence is intact but its action is inhibited by psychic tension…In the cases of neurasthenic impotence, the mechanism of detumescence is not inhibited but, on the contrary, more or less enfeebled…In all these cases the main point is to allay the patient's terror (Ellis, 1954, Orig. 1933, p. 307).

Life's repressive and pressure-laden circumstances contributed decisively to sexual dysfunction in Ellis's view. The solution could be to mitigate a patient's anxiety ('terror') or, as need be, to invoke a surgeon's aid in cases of "physical defects or weakness" (Ellis, 1954, Orig. 1933, p. 308). In all cases—psychic impotence, neurasthenic impotence, and constitutional inability—Ellis perceived a necessity for psychological interventions (Ellis, 1954, Orig. 1933, p. 308). In this regard, Ellis's

work is remarkably forward-thinking, anticipating the current trend towards integrative biopsychosocial treatment. By contrast, it has been argued that Freud's influence served to propel the discipline towards an essentially psychological approach to the sexual dysfunctions (Hartmann, 2009; McLaren, 2007).

2.5.4. Freud and the Psychoanalytic Model

As established, physicians and psychiatrists—including Krafft-Ebing and Ellis—began to propose neurasthenia, nervous illness and the intense pressures of middle-class life as underlying men's sexual dysfunctions, both before Freud and concurrent to his writings (Robinson, 1976). Freud's work—which widely argued that the germ of most psychopathological conditions were present in nearly everyone's psyche—furthered the discourse on nervous repression and offered a range of sexual theories, such as the Oedipus complex, the Madonna-Whore tension, and the idea of triphasic sexual development, which would dominate theory and treatment for more than half of the twentieth century (Hartmann, 2009). Perhaps the most essential manifestation of Freud's influence was the general professional shift towards psychological explanations of men's sexual problems, and the increased prevalence of psychotherapeutic (specifically psychoanalytic) treatments for these. With Freud, it appears, the pendulum swung decisively towards the psychological.

Despite Freud's influence on the treatment of sexual problems through the twentieth century, explicit attention to sexual dysfunction per se (i.e. sexual disorders as classified by standard diagnostic systems) was negligible in his work; Freud examined issues relevant to men's sexual dysfunctions in the *Three Essays on the Theory of Sexuality* (1961h) touched on the issue in "On the Universal Tendency to Debasement in the Sphere of Love" (1961f), and wrote, in the preface to Steiner's *The Psychical Disorders of Male Potency*:

> The sexual function is liable to a great number of disturbances, most of which exhibit the characteristics of simple inhibitions. They are classed together as psychical impotence…In men the chief stages at which the inhibition occurs are shown by: a turning away of the libido at the very beginning of the process (psychical-unpleasure); an absence of the physical preparation for it (lack of erection); an abridgement of the sexual act (*ejaculatio praecox*), an occurrence which might equally well be regarded as a symptom; an arrest of the act before it has reached its natural conclusion (absence of ejaculation); or a non-appearance of the psychical outcome (lack of the feeling of pleasure in

orgasm) (1961g, pp. 345-346).

This statement is, conceptually, remarkably similar to the current diagnostic categories found in the *Diagnostic and Statistical Manual* of the American Psychiatric Association, including *DSM-IV-TR* and *DSM-5,* a likeness that may reflect Freud's enduring influence in the discipline. Research suggests that, until the 1960s, sexual dysfunctions were treated predominantly by psychiatrists working within the psychoanalytic model (Hartmann, 2009; Waldinger, 2006). Yet, since Freud had written very little about sexual dysfunctions, per se, practitioners were forced to apply generally psychoanalytic concepts ex post facto, to describe and treat the sexual dysfunctions (Berry, 2013a). Additionally, the theoretical and clinical contributions Freud made to sex therapy were essentially psychological and psychosocial in orientation, generally omitting biogenic factors. Under the influence of Freudian psychoanalysis, it may be argued, sex therapy was reductively psychological in orientation, failing to provide a theoretical account of, or treatment recommendations for, dysfunctions' possible biological causes.

For the first half of the twentieth century (from the early 1900s until, roughly, the 1960s), sex therapy fell largely within the arena of psychoanalysis. In this system, a man's sexual dysfunction generally was attributed to unresolved Oedipal desire and/or stunted phasic development. In Freud's theory of infantile sexuality, the infant moved teleologically through the oral and anal stages to the genital stage, which would be re-awakened (after a "latency period") in adolescence (Freud, 1961h), failure to move through these stages, or an unconscious, Oedipal sexual fixation on the mother could yield a number of psychosexual outcomes, including dysfunction. Additionally, for genital sexual integration—the proper, natural outcome of phasic development in the Freudian schema—the "sensual" and "affectionate" currents in the unconscious had to be functionally integrated (Freud, 1961f). The dissonance between these two elements, apparent in some men's psychosexuality, was the basis of Freud's widely-quoted assertion: "where they love they do not desire and where they desire they cannot love" (Freud, 1961f, p. 183). This theory captures the essence of Freud's Virgin-Whore dichotomy: a man had to reconcile the archetypal, 'virginal' figure of the mother with the sexually enticing archetype of the "whore" in order to be sexually integrated and genitally functional with his wife.

In short, research suggests that Freud's influence over sexual theory and sex therapy through the first half of the twentieth century was pervasive, and sexual

problems were treated predominantly by psychiatrists working within the psychoanalytic paradigm (McLaren, 2007). Problematically, this methodology did not lend itself to measurement, and was at odds with the rise of scientific empiricism in psychology, and with the increasing emphasis on biology as a site of both cause and cure for the sexual dysfunctions. At the opposite end of the spectrum, Alfred Kinsey's quantitative and statistical work exerted a significant influence on Western sexology and, though less directly, on the sex therapy field.

2.5.5. Alfred Kinsey: Sexual Statistician

In apparent contrast to the psychoanalytic approach, Kinsey's work was essentially quantitative, designed to observe and measure human sexual behaviour. Between 1938 and 1956, Kinsey— a biologist and professor of zoology at Indiana University—and his associates conducted eighteen thousand personal interviews, which aimed to uncover the sexual behaviours of average American citizens. His two key works, *Sexual Behavior in the Human Male* (Kinsey, Pomeroy, & Martin, 1948) and *Sexual Behavior in the Human Female* (Kinsey, Pomeroy, & Martin, 1953), presented a highly statistical picture of Americans' sexual behaviours[12]. Kinsey's work focused on the quantitative measurement of sexual behaviours, primarily examining functional sexual response and behaviour. As such, his attention to sexual dysfunction was limited and predominantly statistical. He makes brief mention of 'impotence', correlating it primarily with age-related decline in sexual functioning (1948, pp. 235-237). According to his statistical analyses, "true ejaculatory impotence…is a very rare phenomenon. Erectile impotence, on the other hand, is not uncommon" (Kinsey et al., 1948, p. 237).[13] Despite his quantitative orientation, Kinsey appears willing to make certain sweeping generalizations on the aetiology of erectile dysfunction, emphasizing the primacy of psychogenesis, and stating, "impotence in a male under 55 years of age is almost always the product of psychologic conflict...In a larger number of cases than has ordinarily been realized, there are psychologic problems involving sex" (1948, p. 323).

Additionally, Kinsey contributed to later quantitative standards of premature ejaculation. "For perhaps three quarters of all males," he wrote

[12] It is of note, however, that Kinsey has been criticized for certain statistical shortcomings, including his failure to use random sampling (Gathorne-Hardy, 1998).
[13] "Ejaculatory impotence" designates an inability to ejaculate, even where intromission and penetrative intercourse have been achieved.

> orgasm is reached within two minutes after the initiation of the sexual relation, and for a not inconsiderable number of males the climax may be reached within less than a minute or even within ten or twenty seconds after coital entrance. Occasionally a male may become so stimulated psychically or through physical petting that he ejaculates before he has effected genital union (Kinsey et al., 1948, p. 580).

Anticipating subsequent work by sex researchers who have argued that premature ejaculation may be, in reality, an adaptive evolutionary response (Hong, 1984; McMahon, 2005; Perelman, McMahon, & Barada, 2004), Kinsey argued that "the idea that the male who responds quickly in a sexual relation is neurotic or otherwise pathologically involved is, in most cases, not justified scientifically" (Kinsey et al., 1948, p. 580). Instead, in these circumstances, rapid ejaculation was considered a straightforward, non-pathological biological response. Comparing humans with genetically similar mammals, like chimpanzees (who have an orgasmic latency of 10 to 20 seconds, in Kinsey's account), Kinsey claims that,

> Far from being abnormal, the human male who is quick in his sexual response is quite normal among the mammals, and usual in his own species. It is curious that the term 'impotence' should have ever been applied to such rapid response. It would be difficult to find another situation in which an individual who was quick and intense in his responses was labeled anything but superior (1948, p. 580).

Yet, orgasm was a crucial measure of sexual success in Kinsey's work (Gathorne-Hardy, 1998). Many later sex therapists have adopted a similar standard, using orgasm and its absence as the diagnostic basis for a number of sexual dysfunctions. Likewise, it may be argued that a great deal of sexual research has adopted a generally empirical/quantitative view of sex and sexual dysfunction—which perceives sexual problems as both psychological and biological processes—a point of resemblance to Kinsey's work. Many sexologists, however, have rejected his claim that quick sexual response is unobjectionable, and premature ejaculation has become a focal point for later cognitive behavioural sexologists, including Masters and Johnson.

2.5.6. Masters and Johnson: Cognitive Behavioural Sex Therapy Pioneers

To contextualize the diminished place of psychodynamic and psychoanalytic theory in more recent research, stressed in chapter 1, it is important to note that in

clinical sexual therapy, in the late 1950s and 1960s, the pendulum began to shift decidedly away from psychoanalysis (Segraves, 1986). Cognitive behavioural treatment approaches started to displace the psychoanalytic paradigm, as psychiatrists' involvement in the field diminished and psychologists' involvement continued to grow. Within the context of cognitive behavioural sex therapy, the biopsychosocial model found its first explicit articulation. Although Masters (a gynaecologist, by training) and Johnson (a psychologist) are broadly accepted as the most influential cognitive behavioural sex therapists of the era, their work drew on prior contributions by a number of theorists, with Goodwach going so far as to contend that while "Masters and Johnson are credited with having revolutionized the treatment of sexual problems with their brief, intensive, behaviourally-oriented interventions…most of their interventions had already been described by Wolpe (Wolpe, 1958)," a pioneer in cognitive behavioural therapy (2005, p. 157).[14] Additionally, the stop-and-start technique, and the "squeeze technique," which Masters and Johnson promoted in the behavioural treatment of premature ejaculation, had already been described by Semans (1956), an American urologist and sex researcher (Glina et al., 2007). In any case, Masters and Johnson's contributions, articulated in a series of vaunted publications (Masters & Johnson, 1966; Masters & Johnson, 1970, 1975; Masters et al., 1982), stand as the most influential cognitive behavioural work in the sex therapy field.

While Masters and Johnson acknowledged the psychodynamic aspects of sexual dysfunction, they argued that the dominant psychodynamic-psychiatric treatment methods were untenably lengthy, costly, and of questionable clinical efficacy (1982, pp. 13, 383). By contrast, cognitive behavioural treatment, they suggested, could generally be completed in a few sessions, with much of the therapeutic work being done by the patient as homework (Ibid. pp. 383-392). Furthermore, their CBT paradigm had exceptionally high (self-reported) rates of efficacy (Ibid. pp. 393), and aimed to acknowledge and treat the biological, social and psychological aspects of sexual dysfunction. Thus, for myriad reasons, their work shifted the field drastically, becoming the dominant sex therapy paradigm from the 1970s onwards.

Whereas Kinsey had used laboratory assays to study human sexuality, Masters and Johnson used clinical observation techniques, observing and analyzing

[14] Masters and Johnson were clearly aware of—and quick to acknowledge—other scholars' influence on their work (1982, p. 394).

human sexual 'cycles,' with a view to understanding the physiological processes underlying the sexual encounter. For Masters and Johnson, sex moved progressively through cyclical stages of: excitement, plateau (stimulation), orgasm, and resolution (a return to the pre-excited state) (Masters & Johnson, 1966). Sexual dysfunction was constituted by non-response, or inappropriate response (i.e. premature ejaculation), during this cycle. Sexual dysfunctions could be attributed to a range of psychogenic causes, but were seen as generally linked to performance anxiety and apprehension in cases of erectile dysfunction (Masters & Johnson, 1970; Masters et al., 1982) and to learned behaviour or conditioned response, often combined with anxiety, in cases of premature ejaculation (Perelman, 2006a). For Masters and Johnson, anxiety is a key cause of men's sexual dysfunctions. Performance anxiety, they asserted, subdues sexual arousal and propels the man into a "spectator role" in which he abstractly observes himself in the sexual encounter, anesthetized to the encounter's arousing stimuli (1982, p. 368).

With these aetiological assertions, and a host of associated treatment recommendations, Masters and Johnson inaugurated the cognitive behavioural era in sex therapy. Their 1966 book, *Human Sexual Response* outlined many of the fundamentals of their biopsychosocial approach to sexual health and treatment. Their second major book, *Human Sexual Inadequacy* (1970) articulated the full cognitive behavioural approach to sexual treatment, which may be seen as their most significant original contribution to the practice of sex therapy. For Masters and Johnson, most sexual problems/dysfunctions could be treated by some combination of systematic desensitization, educational exercises, and cognitive restructuring. "The operant approach to behavioral therapy," they write, "is to carefully analyze the problematic behavior (e.g., the sexual dysfunction) and to use positive and negative reinforcers best suited to the individual case" (1982, p. 394).

Masters and Johnson recommended the squeeze technique and the stop and start technique for the treatment of premature ejaculation. In the squeeze technique, the man (or preferably his partner) periodically desists stimulation, and squeezes the penis, using the thumb on the frenulum and the "first and second fingers just above and below the coronal ridge on the opposite side of the penis" (alternatively, the same pressure can be applied at the base of the penis (1982, p. 390). In the "stop-start" technique, the "female [sic.] partner stimulates the penis manually until the man feels that he is rapidly approaching ejaculation, at which time she [sic.] stops all stimulation until the sense of ejaculatory urgency disappears. Stimulation then

begins again, and the stop-start cycle is repeated several times" (Ibid. 394). These physiological interventions could be prescribed irrespective of the aetiological pathway of the ejaculatory problem.

Arguably, Masters and Johnson's most significant treatment recommendation is the "sensate focus" technique. Widely studied and verified, research suggests that the sensate focus method continues to be a key technique in the sex therapy field (Coren, Nath, & Prout, 2009; de Villers & Turgeon, 2005; Hawton, Catalan, & Fagg, 1992; Heiman & Meston, 1997; Sarwer & Durlak, 1997). Data from this research project suggest that contemporary sex therapists make significant use of Masters and Johnson's sensate focus technique—or some variation thereof—as a primary intervention in the treatment of a wide variety of sexual problems.

Within Masters and Johnson's model of sensate focus therapy, a couple moves through a sequence of steps designed to restructure the dysfunctional partner's sexual cognition, reduce performance-demand, alleviate anxiety, and reduce or eliminate spectatoring, thereby helping the couple work towards more satisfying sexual encounters. In the first stage of therapy, two sessions of non-genital touching are prescribed. These sessions are designed to establish sensual and intimate stimulation without the pressure of intercourse; intercourse is prohibited at this stage. In the second stage, "touching is expanded to include the breasts and genitals" though intercourse remains off-limits, and the emphasis continues to be "on awareness of physical sensations and not on the expectation of a particular sexual response" (Masters et al., 1982, p. 388). The third stage involves mutual touching (instead of taking turns touching one another). In the final stages, the couple engages in the same types of touching, but the receptive partner is advised to assume a mounted position and initiate intromission, if they[15] desire to do so (and assuming erection has been attained) (Ibid. 389). The process is intended to culminate in intercourse-with-thrusting.

Within Masters and Johnson's sex therapy model, anxiety-reduction, the elimination of spectatoring, and systematic desensitization, are essential psychosocial mechanisms of change, to be utilized in conjunction with physiological interventions (i.e. the squeeze technique and the stop-start method). These functions, alongside the sensate focus exercises, were widely adopted by sex therapists during the 1970s and

[15] Masters and Johnson's work generally uses a heterosexual couple model in describing sensate focus therapy, though research suggests that sensate focus techniques may be useful for same-sex relationship and queer clients (Lasenza, 2010; McWhirter & Mattison, 1978; Reece, 1982). More research in these areas—and especially research on the use of sensate focus techniques with transgender clients—appears to be warranted.

1980s (Bancroft, 1977; Leiblum & Pervin, 1980; LoPiccolo, 1977), and continue to be seen as core aspects of clinical sex therapy (Althof et al., 2005; Perelman, 2006b; Wincze & Carey, 2001). Masters and Johnson's work is, arguably, preeminently influential in the sex therapy field, and was clearly instrumental in entrenching the biopsychosocial paradigm in the human sexual health sciences.

2.5.7. The Legacies of History: How Past Developments Have Contributed to the Current Treatment Context

The evolution of sexual science through the twentieth century culminated in a largely psychological orientation towards sexual dysfunction and sex therapy. Throughout the twentieth century, sexual dysfunctions were predominantly cast as psychogenic, and psychotherapy was the dominant treatment approach, with cognitive behavioural methods increasing in importance through the latter half of the 1900s. From the nineteen sixties onwards, the work of key sex therapists, including Masters and Johnson, helped to establish a more nuanced, biopsychosocially informed treatment model. However, the implementation of this type of multi-modal practice has proven challenging. Thus, McCarthy and McDonald write, "from 1970 until 1998 the most common causes of sexual dysfunctions were believed to be psychological and relational factors and these were the focus of therapeutic interventions. With the advent of Viagra… the pendulum has swung to the opposite extreme for both professionals and the public" (McCarthy & McDonald, 2009a, p. 30).[16] While the biopsychosocial model is broadly acknowledged as a process of care standard in the sexual health field (Montorsi, Adaikan, et al., 2010; Montorsi, Basson, et al., 2010), further research on the practical implementation of integrative practice, encompassing both medical and psychosocial therapies, is needed.

This chapter has traced the historical path through which the biopsychosocial model and the era of pharmaceutical treatments have emerged. The priority of methodical scientific practice, the commitment to theory-driven psychotherapeutic treatment, and an attempt to find the balance between the contributions of the body, mind, and social/relational factors have developed out of this historical legacy. This research project is situated within this heritage, stressing the importance of sexuality

[16] As the following section indicates, the medicalization of sex therapy was apparent in biomedical interventions popularized in the 1980s. Although the introduction of Viagra in 1998 was a decisive moment in the treatment field, physical medicine had already begun to stake a claim in the treatment of sexual dysfunctions.

(asserting, as stated in chapter 1, that ‘ sex matters’) and the clinical value of psychotherapeutic intervention.

The historical movements described in chapter 2 indicate the relevance of this research project. As shown in this chapter, the treatment arena shifted first towards psychological interpretations and treatment structures grounded in psychodynamic thought. However, a subsequent pronounced shift towards cognitive behavioural interventions calls into question the current place of psychodynamic methods within treatment context. The following chapters will further clarify the contemporary treatment milieu, and examine where psychodynamic theory and practice fit in a field that aims to balance the multiple facets of the biopsychosocial model.

CHAPTER 3. CONTEMPORARY CONTEXT OF TREATMENT: SEX THERAPY IN A BIOMEDICAL ERA

In order to situate this research project within the current clinical context it is necessary to consider several core aspects of contemporary treatment, which were identified in chapter 1, in greater detail. In evaluating the psychotherapeutic interventions used in the treatment of men’s sexual problems, it is crucial to establish the importance of psychotherapy research in the sexual health field vis-à-vis recent medical treatment developments. Therefore, this chapter discusses the current interaction between the psychological specialities and medical treatment options under the framework of the biopsychosocial model. A specific discussion of the development of the biopsychosocial paradigm serves to clarify the complexity of the interaction between these factors in clinical practice.

Chapter 3 describes these essential aspects of the contemporary treatment context, considering the scope and prevalence of male sexual dysfunction, recent developments in both psychosexual therapy and medicine (including recent pharmacological advances), and the development of the biopsychosocial paradigm. The chapter illustrates that, despite the high level of emphasis on medical and pharmaceutical treatments in recent years, there is an increasing recognition of the complementary and integrative use of psychotherapeutic methods, and that research on psychotherapeutic paradigms—including psychodynamic methods—in the treatment of sexual dysfunction, is clearly warranted.

3.1. Male Sexual Dysfunction: The Scope and Prevalence of the Problem

Male sexual dysfunction is common. Laumann et al.'s widely cited survey on the prevalence of sexual dysfunctions in the United States suggests an overall combined rate of 31% amongst American men (Laumann et al., 1999). The Global Survey of Sexual Attitudes and Behavior, conducted between 2001 and 2002, provides comparable data for 27,000 men and women between 40 and 80 years of age, in 29 countries, indicating "early ejaculation" as the most common male dysfunction, with a 14% prevalence rate, and "erectile difficulties" as the second most common, with a 10% prevalence (Nicolosi et al., 2004). The Men's Attitudes to Life Events and Sexuality Study, conducted in 2001, surveyed 27,839 men between 20 and 75 years of age, determining an overall Erectile Dysfunction prevalence rate of 16% in a sampling of men from eight countries, including the United Kingdom, the United States, Germany, France, Italy, Spain, Mexico and Brazil (Rosen et al., 2004). Across studies, DeRogatis and Burnett suggest, overall rates of Erectile Dysfunction range "from 10% to 20%, with the majority of studies reporting an overall rate closer to 20%" (DeRogatis & Burnett, 2008, p. 296). Furthermore, "the findings suggest that rapid ejaculation (RE) is the most prevalent male dysfunction with rates of occurrence ranging from 14% to 30%" (Ibid: 296-297). Laumann et al. report that 15.8% of men indicated a lack of sexual desire, enduring for several months or more, during the year prior to the survey (1999), and Heiman indicates that sexual problems in general are "highly prevalent", with community sample estimates ranging from 10% to 52% of men (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994; Heiman, 2002; Laumann et al., 1999; Lewis et al., 2010).

DeRogatis and Burnett caution against putting too much stock in exact prevalence statistics, however, due to the imprecision of the diagnostic system for sexual dysfunctions (a concern addressed at length in chapter 6), the preponderance of observational and descriptive studies (as opposed to analytic and experimental studies), and because "cases of sexual dysfunction seen in the clinic represent only a minor fraction of the range of cases of sexual disorders present in the population" (DeRogatis & Burnett, 2008: 289-290). It may suffice to note that irrespective of exact numbers, sexual problems and dysfunctions are highly prevalent, globally. In conjunction with high prevalence, the high priority placed on sexual functioning has contributed to the development of a multidisciplinary body of theory on sexual functioning, and the development of multi-modal and biopsychosocial models

designed to treat dysfunctions. This chapter describes some of the recent developments in the discipline, outlines some key features of the contemporary context, including the tension between biomedical/pharmacological models and integrative/multi-modal models, and explains the combinative treatment model currently advocated by many therapists.

3.2.1 Recent Biomedical Treatment Developments

As indicated in chapter 2, through most of the twentieth century, treatment for the sexual dysfunctions tended to be psychologically oriented (Goodwach, 2005; Waldinger, 2008). Increasingly from the 1970s onward, however, clinicians began to acknowledge the biological and social dimensions of a patient's health, with the biopsychosocial model gaining prominence in the mid 1980s (Althof, 2006b). Many professionals in the field acknowledge three facets that we must consider in assessing and treating men's sexual dysfunctions: the biological (i.e. physiological), the psychological, and the social (sometimes the latter two are considered together, under the classification "psychosocial") (Denman, 2004; Melnik, Soares, & Nasello, 2008b; Metz & McCarthy, 2005; Perelman, 2006b). Biopsychosocial treatment models emphasize

> that sexuality is a multi-causal, multi-dimensional, complex phenomenon requiring assessment and targeted treatment interventions for the man, woman and couple…The assumption is that, at the core, sexuality is a psychological, interpersonal process, rather than a biological, individual process (McCarthy & McDonald, 2009a, p. 31).

This perspective appears to be widely accepted in the sex therapy field. Yet, in recent decades, concurrent to the emergence of the biopsychosocial paradigm, biomedical methods and new biotechnologies have begun to take hold in the medical sphere, embodied in a range of physical treatments. Throughout the 1980s and 1990s, health practitioners used an array of physiological methods, including: vasodilator injection therapies (Segraves, Bari, Segraves, & Spirnak, 1991) hormone replacement therapy (Morales et al., 2004), vacuum pump therapy (Pinsky, Chawla, & Hellstrom, 2010) and penile implant surgeries to treat erectile dysfunction, and selective serotonergic reuptake inhibitors (SSRIs—antidepressants) to treat premature ejaculation off-label (Perelman, 2006a). Thus, it appears that, even prior to the advent of Viagra, treatment of men's sexual dysfunctions may have begun to shift towards a pharmacological and physiological treatment model, administered in the medical

arena (Althof, 2006b). It has been argued that the advent of Viagra™ (sildenafil), in 1998 in the US and the other PDE5i drugs, Cialias™ (tadalafil) and Levitra™ (vardenafil), in 2004, has further entrenched this physiological orientation (Tiefer, 2006).

3.2.2. Recent Developments in Psychotherapeutic Sex Therapy

Some researchers have proposed that sex therapy may be in decline, due largely to the medicalization of sexual dysfunction treatment in the 1980s and early 1990s, and the introduction of new pharmacotherapies (Binik & Meana, 2009). Sex therapists' imputed failure to innovate and advance the discipline elicited Schover and Leiblum's widely cited 1994 work on the "stagnation" of the sex therapy field . According to Schover and Leiblum, the field had become overreliant on pivotal works by Master's and Johnson, and Kaplan, and had neglected to formulate new theories, study methods, or clinical practice models. Schover and Leiblum explicitly challenged sex therapists to devise new methods, to advance and reinvigorate the discipline.

Throughout this research project—through assessment of the current published research, and in the data derived through this survey of clinical practitioners—evidence seems to strongly indicated that within the past two decades the sex therapy field has evolved significantly through the implementation of biopsychosocial practice, and multidimensional, integrative treatment practices (Binik & Hall, 2014; Leiblum, 2007b). In particular, a substantial number of leading researchers and clinicians have consistently and persuasively emphasized the importance and utility of the biopsychosocial treatment model (Althof, 2010b; Hall, 2011; Metz & McCarthy, 2005; Perelman, 2006b) and the value of integrative/combined therapies that draw on both pharmacotherapy and psychotherapy (Althof, 2006b; Perelman, 2005b, 2006a). These treatment paradigms are widely taken as the standard for current and future sex therapy.

Balon, Segraves, Levine, Rosen and others have advanced the biomedical understanding of treatment, and promoted the integrative model in the medical sphere (Balon & Segraves, 2009; Levine, Risen, & Althof, 2003; Rosen, 2000). McCarthy and Fucito, Wincze and Carey, and others have argued for an intimacy-based understanding of sexual functioning (rather than a performance based model), and a couple/relationship-based approach to sex therapy (McCarthy & Fucito, 2005; Wincze & Carey, 2001). DeRogatis and others have established the importance of

diagnostic interviews, and developed measures of sexual functioning (DeRogatis, 1997; DeRogatis & Balon, 2009; Wylie, 2008). Numerous theorists have explored the epidemiology of the sexual dysfunctions (DeRogatis & Burnett, 2008; Hartmann & Waldinger, 2005; Johnson, Phelps, & Cottler, 2004; Rosen, Wing, Schneider, & al, 2005; Shrestha & Segraves, 2009; Waldinger, 2007). Numerous theorists, including many of the aforementioned, have argued for substantive changes to psychiatric diagnostic frameworks (Balon, 2008; Balon, Segraves, & Clayton, 2007; Binik, 2005; Brotto, 2010b; Kleinplatz, 2012b; Moser & Kleinplatz, 2005; Vroege, Gijs, & Hengeveld, 1998; Waldinger, 2007; Waldinger & Schweitzer, 2006a, 2006b; Waldinger & Schweitzer, 2007). Mulcahy and other medical professionals have contributed to the urological understanding of men's sexual dysfunctions (Mulcahy, 2006). A range of theorists have contributed empirical data on men's sexual dysfunctions, though it has been suggested that more empirical work is still needed (Althof, 2010b; Laumann et al., 1999; Nicolosi et al., 2004; van Lankveld, Leusink, van Diest, Gijs, & Slob, 2009). Recently, a number of theorists have proposed innovative new therapy techniques, including internet therapy (Althof, 2010b; Hall, 2004; Leusink, 2006; McCabe et al., 2010; McCabe & Price, 2008; McCabe, Price, Piterman, & Lording, 2008; van Lankveld et al., 2009) and multimedia therapy (Optale, Marin, Pastore, Nasta, & Pianon, 2003). Additionally, critically-oriented sex therapy researchers have begun to explore the applicability of current and new clinical practices for non-normative clinical groups, including LGBTQ and openly non-monogamous communities (Barker, 2011a, 2011b; Barker & Langdridge, 2010a).

Published research indicates that sex therapy has a high level of clinical efficacy, as a stand-alone treatment, or as a complement to pharmacotherapy (Melnik & Abdo, 2005; Melnik, Soares, et al., 2008b). This proven utility is at the core of sex therapists' assertions that even when a dysfunction is biogenic, psychotherapy often has an important role to play in treatment (Althof, 2010b; Perelman, 2006a). It has been asserted, however, that there may be a lack of integration between psychotherapeutic sex therapy and biomedical therapy (McCarthy & Fucito, 2005; Metz & McCarthy, 2005; Perelman, 2005b). Nonetheless, as empirical research has confirmed the efficacy of psychotherapy in treating sexual dysfunctions—and clinical assays additionally establish the merit of biopsychosocial and integrative treatments for the sexual dysfunctions—it appears that sex therapists may routinely take an integrative and biopsychosocially-oriented approach to the treatment of

men's sexual problems, a possibility that is evaluated explicitly in this study, and related research (Banner & Anderson, 2007; Berry & Berry, 2013a, 2014; Mezzich & Hernández Serrano, 2006; Rosen, 2007). A principal aim of this research project is to examine the role that psychotherapeutic methods play within the biopsychosocial, integrative treatment framework. Consequently, in considering the function of psychotherapy in treating male sexual dysfunction, it is necessary to evaluate the contemporary treatment context, and specifically the apparent disjuncture between psychotherapeutic sex therapy and the current emphasis on pharmacotherapy, in the biomedical treatment sphere.

3.2.3. Conflicting Paradigms? Sex Therapy and Biomedicine

Despite the high level of emphasis on biopsychosocial practice in the sex therapy literature, it has been cogently argued that pharmacotherapy presents a significant challenge to psychotherapeutic sex therapy (Althof, 2006b; Tiefer, 2008; Waldinger, 2008). The impact of Viagra and the other PDE5is, and the off-label prescription of antidepressants in the SSRI family for the treatment of premature ejaculation, ostensibly put emphasis on the biological facets of sexual dysfunctions, potentially obscuring their psychosocial facets. Some sex therapy researchers hold that this biomedical trend is fostering the conception that pharmacotherapy constitutes sufficient cure (Waldinger, 2008). In effect, sexual dysfunctions, as Althof writes, have broadly been re-cast "as medical problems" requiring "medical solutions" (Althof, 2006b, p. 117). This re-conceptualization is in part an artifact of the aggressive advertising and promotional campaigns mounted by drug companies. Other factors contributing to this mentality may include: the established physiological efficacy of these treatments (at least in the case of the PDE5i drugs, and the SSRIs), patients' understandable desire for quick, easy solutions to their sexual problems (Althof, 2006b; Tiefer, 2012), and physicians' zealous use of prescriptions and general lack of expertise in psychotherapeutic treatment (Perelman, 2005b; Tsimitsiou et al., 2006).

However, it is important to note that researchers vary in their assessment of the impact of sexual medicine on sex therapy in the contemporary treatment field. While the tension between medical and psychological practice is widely highlighted, some clinician-researchers hold that sex therapy and medical treatment may be more complementary than first thought, in light of the push towards multidisciplinary

integration. "Unpredictably," Binik and Hall write in the foreword to the most recent edition of *Principles and Practice of Sex Therapy*,

> sex therapy and sexual medicine are rather companionable bedfellows. Often sexual medicine interventions aid function (provide blood flow for an erection, hormones for desire), while sex therapy provides the opportunity and context to be sexual (2014, p. xi).

It is held that in order to determine the points of complementarity and disagreement between medical and psychotherapeutic models of treatment, and to facilitate the development or enhancement of practical methods for implementing the biopsychosocial model (a point discussed at length in chapter 5 of this dissertation), further research is needed (Berry & Berry, 2013a). The application of psychodynamic techniques within this type of biopsychosocial framework is a primary consideration in this research project.

Additionally, due to the salience of pharmaceutical treatments, it is important to note that medical treatments for men's sexual dysfunctions are not limited to drug therapies. Simple surgical procedures, for instance, can be used to correct short frenulum, which can cause pain during intercourse (Gyftopoulos, 2009), and sexual dysfunction in morbidly obese men has shown significant improvements after gastric by-pass surgery (Dallal et al., 2008). Additionally, many patients who are non-responsive or refractory to the PDE5is, or for whom these drugs are contraindicated, continue to get penile implants (Wilson & Mulcahy, 2006), or use vacuum pumps (Wessells, 2006) to restore erectile functioning. Nonetheless, pharmacotherapy is the most widely used bioactive treatment methodology in the medical field (Grace, Potts, Gavey, & Vares, 2006; Marshall, 2006; Tiefer, 2006).

3.2.4. Medical Treatment of Sexual Dysfunction

Pharmacological treatments fall generally into three categories: oral agents (i.e. PDE5is and SSRIs), localized treatments (i.e. vasodilators injected into the penis to treat ED, or topical anaesthetics to treat PE), and hormone therapy (i.e. testosterone replacement therapy). The Phosphodiesterase 5 inhibitors (PDE5is), and Selective Serotonin Reuptake Inhibitors (SSRIs) are clinically efficacious in treating erectile dysfunction and premature ejaculation, respectively, at a physiological level (*International Journal of Impotence Research*, 2003b, 2003c). Although this research project focuses primarily on the psychotherapeutic methods used to treat

sexual dysfunction, a brief discussion of the mechanisms and evidence for the aforementioned biomedical treatments is warranted.

While the idea of a normalized sexual response cycle is critiqued in later chapters of this dissertation, it is important to note that a linear, biological model of sexual response—which moves from arousal through stimulation, to orgasm—is presumed in much of the medical research. Classic experiments helped to determine several physiological phases in men's sexual response cycle, and tumescence/erection, ejaculation and detumescence are understood to comprise the overall physical response arc (De Groat & Booth, 1980). Within the medical framework, in response to physical and/or cognitive factors (i.e. stimulus or stimulation), parasympathetic nerve fibres provide signals for erection, whilst at ejaculation (usually corresponding with orgasm), sympathetic nerve fibres signal the prostate, seminal vesicles and vas deferens to facilitate emission (the secretion of fluids into body compartments) and ejaculation (expulsion of seminal fluid from the body). Ejaculation is caused by contractions of striated muscle lead, stimulated by innervation by the pudendal nerve. These nerves are modulated by higher centres and are influenced by psychological and cognitive processes. Following ejaculation, the normally ensuing process is detumescence, a return to flaccidity, which involves a change in haemodynamics leading to increased blood drainage from the corpus cavernosum.

At the physiological level, erection is a vascular process in which the penis engorges with blood; this tumescence results from the relaxation of smooth muscle tissue, arterial dilation, and venous constriction (De Tejada et al., 2004). During erection, lacunae within the corpus cavernosa (expandable, 'sponge-like' penile tissue) fill with blood. This process causes the physical distension of the corpus cavernosum. The filling of the lacunar spaces also results in the physical compression of the emissary veins (responsible for draining blood out of the penis) against the tunica albuginea (a fibrous layer of connective tissue, surrounding the corpus cavernosa), preventing blood from draining as it would during flaccidity. At the cellular level, fluctuant levels of calcium dictate the contraction and relaxation of smooth muscle, controlling the arterial system in the penis and regulating erection (Ibid.).

The degree of contraction of smooth muscle tissue relates to the physical calibre of the arteries providing the blood supply (Ibid.). Nitric oxide has been implicated as the predominant messenger effecting an enzyme cascade that allows

smooth muscle cells to modulate intracellular calcium concentrations; nitric oxide, therefore, serves as a catalyst for the erectile process (Burnett, 1997). Despite the importance of nitric oxide, pharmacologists have exploited a 'downstream' target for the treatment of erectile dysfunction. Phosphodiesterase is an enzyme responsible for ending the catalytic process that nitric oxide began. During penile flaccidity, blood flow tends towards a balance between delivery and drainage; by preventing the normal action of phosphodiesterase, the flow cycle can be interrupted, increasing the ratio of blood delivery relative to drainage (Andersson, 2001). A number of isoforms (different forms of this protein) of phosphodiesterase exist, and the one predominantly expressed in the corpus cavernosum is isoform 5 (PDE5). This semi-specific property has allowed pharmaceutical manufacturers to design drugs—the PDE5 inhibitors (PDE5is)—that are administered orally and work in a relatively specific way to influence targets found within the penis (Gerthoffer & Larsen, 2000). By inhibiting phosphodiesterase 5, the PDE5i drugs facilitate ongoing smooth muscle relaxation and in turn erection (International Journal of Impotence Research, 2003a). Sildenafil (Viagra™), tadalafil (Cialias™) and vardenafil (Levitra™) are in this drug family, and work through this type of pharmacodynamic mechanism. Due to the PDE5 inhibitor drugs' relative selectivity, they are well tolerated by most patients. A significant body of research indicates that PDE5i drugs are physiologically effective in a majority of cases of erectile dysfunction, and are the most prevalently used pharmacotherapy for erectile dysfunction (Brock et al., 2002; Hellstrom, Gittelman, Karlin, Thibonnier, & Padma-Nathan, 2002; Montorsi et al., 1999; Padma-Nathan, 1998; Porst, Padma-Nathan, et al., 2003; Porst et al., 2001; Porst, Young, Schmidt, Buvat, & Group, 2003).

Intracavernosal injection therapy (ICI) is another relatively common pharmacological treatment for erectile dysfunction. Although intracavernosal injections are regularly used, and some men prefer to use this method for its consistency of results, the advent of the PDE5i drugs has significantly reduced intracavernosal injections' use rates, and injection therapy is often considered a "second-tier" pharmacological treatment, prescribed for men who are non-responsive to, or unable to take, PDE5 inhibitors (Tsao & Nehra, 2006). This technique involves direct injection of vasoactive drugs into the corpus cavernosum of the penis. Similar to the PDE5Is, this treatment influences the haemodynamics of the corpus cavernosum, influencing blood flow in erectile tissues. A substantial body of

evidence suggests that intracavernosal injection therapy is efficacious (Montorsi et al., 2003; Mulhall & Simmons, 2007; Rowland, Boedhoe, Dohle, & Slob, 1999).

Systemic androgen therapy also plays a role in the pharmacological treatment of erectile dysfunction. While androgens are used widely in treating hypogonadism and declining testosterone in ageing males, evidence suggests that they may provide little benefit in the treatment of younger men with normal gonad function (Heaton & Morales, 2006). Recent research, however, indicates that concomitant use of PDE5 inhibitors and testosterone therapy may offer synergistic results in the treatment of erectile dysfunction across age groups (Shabsigh et al., 2006).

In addition to drug therapy, penile implant surgeries and vacuum devices are also used to treat erectile dysfunction. These mechanical treatments, while generally considered efficacious, have varied satisfaction reports (Hellstrom et al., 2010). Vacuum constriction devices (VCDs) are generally seen as a first-line treatment, useful for erectile dysfunction patients who want to avoid, or cannot undergo, pharmacotherapy (Riley & Riley, 2009). A VCD is a vacuum-activated cylinder, which uses pressure to draw blood into the penis, causing it to enlarge and rigidify. After engorgement, a latex band is placed around the base of the penis, to prevent hematic drainage. While, "the penis is not physiologically erect…the rigidity is usually sufficient to enable sexual intercourse" (Ibid. 240). Like intracavernosal injections, use of vacuum constriction devices has diminished significantly since the introduction of the PDE5is (Wessells, 2006).

By virtue of their attendant risks—risk of device failure, surgery complication, or infection—and irreversibility (penile implant surgery obliterates the normal functioning of the corpus cavernosa) penile implants are generally considered a third-line treatment (Wilson & Mulcahy, 2006). Penile implant surgeries are often used for men with complicating physiological conditions, such as Peyronie's disease (a medical condition causing pronounced curvature of the penis). "There are," Mulcahy et al. write, "three classes of penile implants, hydraulic, semirigid and soft silicone" (2004, p. 471). All types of penile implant are inserted surgically into the penile shaft. Generally, penile implants would not be indicated for patients who derive benefit from other treatments (Ibid.).

Biomedical treatments for premature ejaculation are more limited than treatments for erectile dysfunction, and are restricted primarily to topical and orally-administered pharmacological agents. Some men topically administer local anaesthetic drugs such as lidocaine and prilocaine, prior to intercourse, to blunt the

tactile sensory afferents (nerve fibres) in the penis. These drugs diminish the sensation from intercourse, in attempt to delay the ejaculatory process, thereby prolonging intercourse (Hellstrom, 2010).

Selective Serotonin Reuptake Inhibitors (SSRIs), commonly prescribed in the treatment of depression, are also used to treat premature ejaculation. While the neuropharmacology of the orgasm and ejaculation processes is markedly complicated, it is recognized that serotonin plays a role and can be exploited pharmacologically. This method is non-specific and can cause side-effects, but generally these medications are well tolerated (Hellstrom, 2011). It has also been suggested that the weak-opioid tramadol is useful for the treatment of premature ejaculation on account of its significant serotonergic effect, but this is an area—as with the general function of serotonergic agents in treating sexual dysfunction—where further research is required (Salem et al., 2008).

3.2.5. The Limitations of Pharmacotherapy

While they are well established in treating erectile dysfunction and premature ejaculation, drug treatments, elective surgeries and vacuum devices are not panaceas for the sexual dysfunctions. Penile implants have high satisfaction scores, but are seen as a "final-resort" treatment, when other treatments have failed or cannot be used (Mulcahy et al., 2004). Satisfaction scores for vacuum constriction devices (VCDs) are inconsistent, and attained lower scores than other methods in a study by Hassan and colleagues (2009; Mulcahy et al., 2004). Testosterone therapy has varied reported results, with some researchers suggesting that it is not in itself a sufficient restorative treatment for sexual functioning, particularly for younger, non-hypogonadal men (Heaton & Morales, 2006). With respect to erectile dysfunction, as Althof notes, it is estimated that 90% of men seeking treatment for ED are treated with PDE5is, and that they are effective for 70% of these men; but it is also estimated that 60-70% of these individuals discontinue this drug treatment within the first three months (Althof, 2006b, 2010b; Rosen et al., 2004). Tiefer (Tiefer, 2007) argues that, while the PDE5is are undeniably effective in the short term, there is little empirical evidence of their effectiveness in ongoing and long-term treatment.[17] Use of SSRIs in treating premature ejaculation is equally fraught by virtue of the legal risks and ethical implications of prescribing drugs off-label.

[17] Further research is warranted to determine whether, for some men, discontinuance may result from the success of PDE5is in breaking the cycle of primarily psychogenic ED (i.e. by instilling confidence in erectile functioning, or helping to instate/re-instate a script of 'successful' sex).

Published research suggests that, for all dysfunctions, the rates of relapse when patients discontinue drug therapies are high (Hatzimouratidis et al., 2010; Montague et al., 2004; Perelman, 2006a), with the implication that, even when they work, drug therapies in and of themselves may be largely palliative rather than curative. An additional concern, Waldinger argues is that pharmaceutical companies, driven by profit-models, may

> 'overmedicalize' sexual medicine. Overmedicalization means that normal phenomena and healthy individuals become pathologized ('you have a sexual disorder') and medicalized ('you need medication'). Overmedicalization is not a characteristic of sexual medicine, but is a well-known marketing strategy of pharmaceutical companies (2008, pp. 181).

Consequently, pharmaceutical companies' push for "overmedicalization" may undermine the integrative diagnostic and therapeutic methodologies required in the biopsychosocial treatment of sexual dysfunctions. Overarchingly, drug therapies' limitations appear to support the hypothesis, manifest in the sex therapy literature, that psychotherapy and combined pharmacotherapy-psychotherapy treatments may foster better and more enduring treatment outcomes than mono-modal drug therapy—a theory increasingly supported by empirical research (Althof & Rosen, 2011; Banner & Anderson, 2007; Berry & Berry, 2014; Melnik, Soares, & Nasello, 2008a; Melnik, Soares, et al., 2008b; Perelman, 2006a).

The biomedical and pharmacological models appear to be linked with specific treatment challenges, above and beyond the limitations of drug therapies. A substantial body of research, for instance, identifies the shortcomings of physician training and practice in dealing with patients' sexual health as a significant challenge (Althof, 2010b; Athanadiasis et al., 2006; Perelman, 2005b; Tsimitsiou et al., 2006; Wylie, 2008). While these concerns are not intended to detract from the intentions or overall competencies of physicians, they do indicate that many physicians may have deficits in both competence and confidence when it comes to dealing with patients' sexual functioning, which may be compounded by the time constraints of physician-consultation in general practice. This is particularly problematic since primary care physicians are a primary point of contact for many individuals with sexual health problems (Athanadiasis et al., 2006). While patients may enter the sexual care system through the care of another medical professional, such as a urologist or cardiologist, research suggests that comparable though less prevalent knowledge and skill deficits persist amongst such specialists (Tsimitsiou et al., 2006). On the whole, there may

be a trend amongst medical professionals to defer to the medicalized and pharmaceutically-oriented treatment model. According to Rowland, this trend threatens to undermine the sex therapy field (2007).

3.2.6. Physicians, Sex Therapy and Barriers to Treatment

In order to understand both the current challenges faced in the sex therapy field and the importance of psychotherapy in the treatment of sexual dysfunction, it is necessary to consider the logistical limitations of medical treatment. Published research identifies a number of common obstacles to sexual diagnostics and treatment in primary care settings, including: insufficient practitioner training and knowledge of sexual health issues, practitioner discomfort in discussing patients' sexual health, privacy concerns, demographic factors (i.e. age and gender of both practitioner and patient), and the practitioner's personal sexual attitudes and mores (i.e. 'conservative' vs. 'liberal') (Athanadiasis et al., 2006; Temple-Smith, Hammond, Pyett, & Presswell, 1996). These factors can contribute to physicians' failure to ask about sexual functioning, despite patients' apparently common assumption that their doctor will broach the subject (Nusbaum & Hamilton, 2002). In general, Tsimitsiou et al. contend, "physicians seem to neglect the patients' [sic.] agenda and the importance of proactively addressing their sexual health concerns, although effective doctor-patient communication and patient-centeredness is a fundamental task in medicine" (2006: 584). It appears that this trend engenders a risk that some patients' sexual dysfunctions may go undiagnosed and untreated.

According to Hartmann & Burkart, patients are often reluctant to seek treatment for sexual dysfunctions, or initiate a dialogue about sexual functioning (2007), and many patients believe the physician has a responsibility to inquire about sexual health and functioning (Perelman, 2006). This confluence of factors may contribute to the reported fact that physicians tend to underestimate the prevalence of sexual concerns and sexual dysfunctions amongst their patients (Nusbaum & Hamilton, 2002). Logically, failure to diagnose cases of sexual dysfunction may reinforce the underestimation of sexual dysfunctions' occurrence. Furthermore, in a study of premature ejaculation in Belgian men, Mak et al. found that men with the most serious sexual dysfunctions and those in the older age cohorts were least likely to report their sexual problems to their physician; this finding suggests that those who are most in need of therapy may be least likely to receive it (2001).

In fact, communication failures, research by Tsimitsiou et al. (2006) and Athanadiasis et al. (2006) suggest, may constitute the primary barrier to physicians' properly diagnosing and treating sexual dysfunctions. In turn, insufficient physician training is a key obstacle to physician-patient communication regarding sexual health and functioning; Tsimitsiou and colleagues found specialized training in communication skills to be the strongest predictor of effective sexual history taking amongst physicians (2006). Further research on physicians' attitudes and practices with respect to sexual dysfunction, especially in regard to integrative biopsychosocial methods, is evidently warranted. Research suggests that many physicians may approach sexual problems and dysfunctions as fundamentally biomedical problems requiring medical (especially physiological and pharmaceutical) solutions.

Consequently, to foster multidisciplinary practice and professional collaboration, it may be worthwhile to offer supplemental training on multimodal, multidisciplinary, and biopsychosocial practice to physicians and other healthcare professionals. This type of training could also target and help resolve an either-or fallacy in the health professions, which, Wincze and Carey argue, is common (2001). In this reductionism, they state, health practitioners,

> dichotomize sexual problems into 'organic' and 'psychogenic' categories. The assumption is that if the problem has an organic basis, then it has to have an organic solution. This approach does not recognize that many sexual problems emerge from a combination of organic and psychogenic factors [or that] even when the etiology is clearly organic, the best solution may be partly or completely psychological in nature (Wincze & Carey, 2001: 162).

It is widely accepted that sexual dysfunctions generally are multi-faceted, encompassing a patient's physiology, psychology, intimate relationships, and previous socio-cultural experiences (Graham & Hall, 2012; Montorsi, Adaikan, et al., 2010; Rowland & Cooper, 2011). However, further high quality empirical research is warranted, to determine: to what extent physicians adhere to a biomedical treatment model (vs. a biopsychosocial model), to what extent physicians collaborate with other practitioners, and how the biopsychosocial model can be effectively implemented in the treatment of sexual dysfunctions.

Sexual therapy researchers widely assert that sexual dysfunctions tend to be multifariously determined, including biological, psychological and social causes (Denman, 2004; Fagan, 2004; McCarthy & McDonald, 2009a; Perelman, 2006b). From this perspective, it stands to reason that their treatment should be comparably

multi-faceted, addressing both organic and psychosocial factors. Althof identifies a number of factors that militate against mono-modal medical treatments, including the wide-ranging impact of the dysfunction (and the potentially self-perpetuating cycles that may emerge), and the relevance of psychological treatments even for primarily biogenic instances of sexual dysfunction (2010: 6). To account for and effectively treat sexual dysfunctions, in light of their complex geneses and ranging effects, sex therapists advocate the use of "combination therapy" (Perelman, 2005) or "integrated treatment" (Althof et al. 2005) models. These terms denote the concurrent or phasic integration of medical and psychosocial treatments. Particularly in light of pharmacotherapies' physiological efficacy, and their high discontinuance rates, combination therapy has become a preferred methodology for many sex therapists (Perelman, 2007; McCarthy & Fucito, 2005).

3.3.1. Integrative Treatment: Combining Psychotherapy and Pharmacotherapy

The importance of psychotherapeutic interventions, and psychotherapy research, is also illustrated by recent evidence that favourable treatment outcomes may be attained in combination sex therapy, when compared with mono-modal medical treatments. There is evidence for combination therapies' effectiveness in treating both erectile dysfunction and premature ejaculation (Banner & Anderson, 2007; Perelman, 2003, 2006a; Steggall, Fowler, & Pryce, 2008). A substantial number of sources suggest combination therapy's utility in treating erectile dysfunction (Althof, 2010b; Hartmann & Langer, 1993; Melnik & Abdo, 2005). For instance, in a pilot study of partnered men (n=53) seeking treatment for psychogenic ED, Banner and Anderson evaluated the comparative effectiveness of: 1) an integrative treatment protocol, which combined sildenafil treatment with CBT-based sex therapy, and 2) sildenafil alone. After four weeks of treatment, 48% of men in the integrative treatment protocol group met the criteria for success on erectile function and 65.5% for satisfaction, as compared with men on sildenafil therapy alone, who had a 29% success rate, and 37.5% satisfaction rate (Banner and Anderson, 2007).

Although the literature on combined treatments for premature ejaculation (like the literature on premature ejaculation more broadly) is limited in comparison with extant research on erectile dysfunction, a number of clinical practitioners have hypothesized that combinative therapy may be more effective, and may have higher continuance rates, than drug therapy alone in treating premature ejaculation

(Perelman, 2006a; Sharlip, 2005). Additionally, clinical guidelines recently published by the International Society for Sexual Medicine (ISSM) recommend the use of combined pharmacotherapy-and-psychotherapy for patients with both lifelong and acquired PE (Althof et al., 2014).

Steggall et al. argue for the use of combination therapy in treating PE, determining that, while pharmacotherapies are effective in delaying ejaculatory response, patient satisfaction depends on more than ejaculatory timing, and that therapy outcomes may also be measured by relationship outcomes, such as relationship satisfaction and partner satisfaction (Steggall et al., 2008). In their research, "self-reported improvement to relationships was established, but did not correlate to the timed ejaculatory delay, i.e. successful treatment did not depend on a timed delay, but on a reintroduction of intimacy" (2008: 365). They determined that improving the ejaculatory latency period was one component of restoring patients' subjective sense of psychosexual health, and that pharmacotherapy can be used to maximize the benefits of psychotherapy, for complete and enduring treatment. Similarly, Perelman contends that increasing ejaculatory latency through drug treatment is only one step in a complete treatment methodology (2006a). Increasing ejaculatory latency period with drugs, he writes, "creates a teachable moment" (Ibid. 1010). This "teachable moment" affords an opportunity for psychotherapists to help patients understand the premonitory sensations that precede ejaculation, and thereby reach a "choice point" wherein they can control the ejaculation process more effectively (Ibid. 1004).

A substantial body of targeted research also indicates the benefits of combination therapy in treating erectile dysfunction and premature ejaculation (Althof, 2010; Aubin et al. 2009; Banner et al., 2007; Brock et al. 2007; Althof, 2006; McCarthy & Fucito, 2005; Perelman, 2005; Phelps et al., 2004; Wylie et al., 2003; Rosen, 2000). Studies suggest that psychotherapy can be as effective as drug treatment in treating psychogenic ED and psychogenic PE, and that combination therapy is often more effective than drug treatment alone, especially in the long-term, as data suggests that patients/clients are more likely to continue treatment under a combined therapy regime. A recent meta-analysis determined that within 8 studies considered, with a total number of 562 patients, a trend towards larger effect of combined treatment, for ED symptoms, than PDE5-I treatment alone, or psychological intervention treatment alone, and that combined treatment was more efficacious on sexual satisfaction than PDE5-I use alone; based on this data, the

authors conclude that "the combination of [psychological intervention] and PDE5-Is is a promising strategy for a favourable outcome in ED and can be considered a first-choice for ED patients" (Schmidt, Munder, Gerger, Frühauf, & Barth, 2014, p. 1376). Melnik and Abdo (2005) conducted a clinical trial analyzing the effectiveness of three treatment conditions for psychogenic erectile dysfunction; these conditions included (1) group therapy combined with sildenafil treatment, (2) sildenafil treatment used alone, and (3) group therapy alone, with no drug treatment. Melnik et al. (2008a) concluded that, in a majority of studies, combined therapy showed a greater continuance rate than drug therapy alone, and found that psychological interventions are as effective in treating psychogenic ED as local injection and vacuum devices. Melnik and Abdo (2005) attained even more pronounced results, determining that, in treating psychogenic ED, combination therapy *and* psychotherapy alone were statistically more effective than drug therapy alone.

Brock et al. (2007) conducted a clinical study using an integrative therapy that combined sildenafil treatment with a "treatment optimization program" consisting of a tear-off information sheet, and an informational brochure and video provided directly to patients; psychotherapy was not provided. Both doctors and patients in the treatment group were satisfied with the TOP. It is noted that there were no statistical differences between the group that received the TOP and the control group, which only received sildenafil treatment. When considered in relation to the aforementioned work by Melnik et al., and other research in this area, Brock et al.'s findings seem to suggest that psychotherapy may be uniquely effective, above and beyond its educational component, and that combination therapies may be most effective if they combine drug therapy with counselling-based psychotherapy. While these and other research projects indicate that the psychosocial aspects of patients' sexual health must be taken into account in the treatment process, it is clear that further research on combinative and integrative biopsychosocial therapy is warranted.

Based on current research, it appears that the success of combination therapies, and the viability of their implementation, depends on effective collaboration between health providers, and effective sexual history-taking by physicians. Tsimitsiou et al. (2006) hold that *psychosocial* treatment orientation (i.e. an awareness of, and willingness to consider, psychological and social aetiological factors) is an important predictor of physicians' willingness to ask about, and competency in dealing with, sexual issues. Research suggests the psychosocial

approach is currently lacking in the medical sphere; "most men with PE," Perelman writes, "are not receiving treatment, secondary to their embarrassment about discussing their condition and a lack of clinician inquiry about sexual dysfunction (2006: 1004). The problem is equally significant for ED and the other dysfunctions. The ways in which medical practitioners can work collaboratively with psychotherapeutic sex therapists is a crucial area for further research, and an important focus of this dissertation, addressed in chapter 5.

3.3.2. The Function of Sex Therapy Within the Integrative Treatment Model

In light of current research on the integrative use of psychological and psychotherapeutic interventions, it is important to evaluate the specific characteristic of the sex therapy paradigm that may be incorporated, alongside medical (especially pharmacological) treatments. As described in chapter 2, the development of sex therapy was strongly informed by the work of Masters and Johnson, which introduced a number of techniques—especially cognitive behavioural techniques—that have become core elements of sex therapy practice. It has been observed, however, that contemporary sex practice is increasingly integrative, drawing on a varied array of psychotherapeutic methods, drawn from a number of psychotherapy modalities (Meana & Jones, 2011; Weeks, 2005). According to Perelman, sex therapists use a range of approaches, including but not limited to: "(a) anxiety reduction and desensitization; (b) cognitive-behavioral interventions; (c) increased sexual stimulation; and (d) interpersonal assertiveness and couples' communication training" (Perelman, 2006b, p. 116). This research project is dedicated principally to evaluating the role that psychodynamic therapy techniques may hold within integrative sex therapy (Shedler, 2010).

Sex therapy treatment format is widely variable and can consist of individual therapy, couple therapy, group therapy, or another format, depending on the specific circumstances; many therapists, however, emphasize the benefits of the couple therapy approach (Atwood, 1993; Hawton et al., 1992; LoPiccolo, 1977; Metz & McCarthy, 2007). A variety of interventions are accepted to have a central place within sex therapy, including: sensate focus exercises, systematic desensitization, behavioural work, psychoeducation, masturbation exercises, and sexual skills and communication training (Althof et al., 2005). Asserting the diversity of the field, Althof writes,

> Sexual therapy techniques comprise behavioral/cognitive interventions as well as psychodynamic, systems, relationship, and educational interventions (e.g., reading, videotapes, illustrations, anatomical models). While employing traditional psychotherapeutic techniques—support, interpretation, confrontation, cognitive reframing, and homework to name a few, sex therapy incorporates specific technical interventions such as sensate focus to diminish performance anxiety, stop-start to help patients with premature ejaculation, [and] directed masturbation for anorgasmia…Effective comprehensive treatment often involves collaboration with other specialists such as urologists…endocrinologists, family practice physicians, internists, cardiologists, neurologists, nurse practitioners, physician assistants, or physical therapists (Althof, 2010b, p. 6).

There is a general consensus that sex therapists should work in consultation with physicians and internists in order to rule out biogenic causes, or treat them, before administering sex therapy, a position strongly substantiated by this research project (McCabe et al., 2010; Wincze, 2009; Wincze & Carey, 2001). Additionally, it is recommended that sex therapists monitor for possible comorbid or contributing psychological conditions, such as depression and substance abuse, during intake, as these may require separate or prior treatment (McCabe et al. 2010). As mentioned above, current research suggests that the biopsychosocial model holds a widely accepted role—as a key treatment standard—in sex therapy, with many sex therapists advocating an integrative and multi-modal approach to treatment.

3.4. The Biopsychosocial Paradigm

In order to contextualize the integrative and multi-disciplinary treatment field within which sex therapists currently work—and within which integrative treatment systems are developed—it is crucial to clearly define the biopsychosocial model, and illustrate its key features. The remaining sections of this chapter are dedicated to a discussion of the biopsychosocial paradigm, and the interrelating biological, psychological and social factors implicated in male sexual dysfunction. In addition to guiding the diagnostic process, the biopsychosocial model determines, to a considerable degree, the treatment formulation (Fagan, 2004; Perelman, 2006b; Rosen et al., 1999). Researchers and clinicians envisage the "psychosocial" component of this paradigm as encompassing psychological factors (including affect, cognition, and life history), relationships (both sexual and non-sexual) and cultural

factors (Fagan, 2004; Levine, 2003; Wincze & Carey, 2001). Biological" factors are understood to include: neurological factors, physiological factors (including basic physical processes and comorbidities), and "lifestyle aspects" (Metz & McCarthy, 2005; Shrestha & Segraves, 2009). The biopsychosocial model is diagnostically and therapeutically holistic, acknowledging a considerable degree of overlap and inter-influence between the elements of the paradigm. Consequently, many health professionals appear to use this model to conceptualize the elements of a client's sexual problem(s), with the understanding that these elements are in actuality non-discrete.

Sexuality, and sexual problems, are seen as encompassing biological, psychological, interpersonal, cultural and lifestyle elements, with the implication that sexual functioning can be undermined by problems originating in any one of these elements (Balon, 2009; Levine, 2003; Levine, Hasan, & Boraz, 2009; Stevenson & Elliott, 2009; Wincze & Carey, 2001). Sexual dysfunctions, therefore, can be expected to have psychological, behavioural, and physiological facets, regardless of their aetiologies. It is held that a dysfunction of psychogenic origin will have both biological and interpersonal repercussions (in addition to psychological ones), and an inherently biogenic dysfunction will have psychological and interpersonal outcomes, which may in turn perpetuate or exacerbate the dysfunction (McCarthy & McDonald, 2009b). Therefore, the biopsychosocial approach endeavours to examine and treat the biological, psychological and social aspects of a sexual dysfunction, under the assumption that all dysfunctions' aetiologies and outcomes involve some combination of these factors.

As illustrated in the previous section, medical approaches to sexual dysfunction may often want for thoroughness, adhering more closely to a biomedical model than a psychosocially-informed treatment system (Althof, 2006b; Tsimitsiou et al., 2006). This healthcare tendency contradicts the accepted principles of comprehensive care and the World Health Organization's "Process of Care Guidelines" laid out in the Proceedings of the World Health Organization's 2nd International Consultation on Erectile and Sexual Dysfunction (Rosen et al., 1999). The current healthcare trend shows an apparent practical tension between the biomedical model and the biopsychosocial treatment approach. "Too often," McCabe et al. argue in a state-of-the-science review, "medical treatments are directed narrowly at a specific sexual dysfunction and fail to address the larger biopsychosocial issues"; citing the high discontinuance rate of patients on drug

treatment, they go on to emphasize that physicians routinely "[fail] to address the relevant psychological and interpersonal issues" (McCabe et al., 2010, p. 333). McCarthy and McDonald (McCarthy & McDonald, 2009a) make much the same contention, in more emphatic terms. "Male sexual dysfunction," they write,

> is perhaps the most extreme example of the biomedical model…Although lip service is given to the comprehensive approach…the reality is that most physicians use medications as the first line of therapy for both ED and premature ejaculation…This is especially true with internists and family practitioners who write the majority of medicinal prescriptions for sexual dysfunction. The concept of assessing the man's past and present attitudes, feelings and behaviors is not integral to the biomedical approach (McCarthy & McDonald, 2009a, p. 31).

Overall, research suggests that the primary care administered by physicians may often fall short of the integrative/holistic standards mandated by the biopsychosocial model (Athanadiasis et al., 2006; Waldinger, 2008). This shortcoming—which researchers suggest is more pronounced amongst general practitioners and internists than specialists (Tsimitsiou et al., 2006)—necessitates the question: how can healthcare practitioners offer the best and most effective care to men seeking treatment for sexual problems? Furthermore, how can psychotherapy be optimized to treat sexual dysfunctions in current sexual health systems?

Research suggests that combination therapy—as outlined above—may be an efficacious starting point for treatment optimization (McCabe et al., 2010; Perelman, 2006b). The combinative use of pharmacotherapy and psychotherapy (and the attendant merger of the biomedical and psychosocial models) is an attempt to address the varied treatment needs of a biopsychosocial problem. As Perelman contends, "restoration of lasting and satisfying sexual function requires a multidimensional understanding of the forces that created the dysfunction" (Perelman, 2006b, p. 105). The apparent implication is that clinicians must be prepared to deal with sexual dysfunctions as biopsychosocial phenomena. As established, in many cases this may require a physician to reorient their approach to treatment and gain supplemental training (Tsimitsiou et al., 2006). Numerous subject experts suggest, however, that physicians, despite their specialist expertise and competencies, are not always capable of treating sexual dysfunctions by themselves, even when they have obtained enhanced subject-specific training (Althof, 2006b; McCarthy & McDonald, 2009a; Perelman, 2003).

It is widely noted that optimal treatment of sexual dysfunction may often be integrative and multidisciplinary, involving professionals working within different areas in the healthcare system. Effective treatment, as Balon holds, does not involve merely supplementing pharmacotherapy with cursory psychotherapeutic techniques (2009). Biopsychosocial treatment may often require interdisciplinary cooperation. The purpose of an integrative biopsychosocial approach, Metz & McCarthy write, "is to be comprehensive: that is, to use all available resources – medical, pharmacological, psychological, relational, and psychosexual skills – to increase pleasure, relationship intimacy, and satisfaction" (Metz & McCarthy, 2007, p. 353). Biopsychosocial care may often necessitate collaboration between sex therapists, internists and general practice physicians, urologists, endocrinologists, cardiologists, and psychiatrists. It is indicated that the types of specialists involved in a given patient's treatment will be dictated by the aetiology of the patient's dysfunction, care resources available, and the parameters of the health-care setting, as well as patient preference (Althof, 2006b). Research participants in this project clearly specify that treatment is often determined, and potentially limited, by both diagnostic and prognostic factors (i.e. what services are required according to the diagnosis and prescribed treatment programme) and logistic factors (i.e. what services can viably be accessed, under the specific circumstances).

3.4.1. The Evolution of the Biopsychosocial Paradigm

Despite the fact that health professionals are still working to develop and optimize integrative biopsychosocial treatment procedures for the sexual dysfunctions, the biopsychosocial model itself is longstanding, both within sex therapy (Masters & Johnson, 1970; Masters et al., 1982; McCarthy & Fucito, 2005) and in the wider clinical arena (Engel, 1977, 1980). According to Ghaemi, in the mental health field, the biopsychosocial approach "grew out of the internecine conflicts between biological reductionism and psychoanalytic orthodoxy that characterized most of the 20th century" (Ghaemi, 2006: 619). Indeed, the progenitors of the biopsychosocial system, Grinker and Engel, were psychoanalytically trained. Yet, the development and increased influence of the biopsychosocial approach has pertained not only to psychoanalytic orthodoxy, but to a wider disciplinary resistance to biomedical reductionism (Frankel, Quill, & McDaniel, 2003). As indicated above, the biopsychosocial approach "[incorporates] and [integrates] biological, psychological, and sociological data in clinical practice" (Ibid. 255). As such, it may

be argued, the commitments espoused in a comprehensive biopsychosocial treatment approach are less eclectic (Ghaemi's concern)—although they certainly draw on a range of methodologies—than holistic. In this regard, the biopsychosocial model may be well suited to the treatment of men's sexual dysfunctions.

Although George Engel is widely credited with advancing the concept of biopsychosocial treatment in the late 1970s and early 1980s (Engel, 1977, 1980), the term was coined earlier by Grinker (Grinker, 1964, 1976). Additionally, the biopsychosocial model's conceptual roots can in some measure be traced back to Adolf Meyer's psychobiology (Meyer, 1948; Meyer, 1957). In fact, Engel acknowledged Meyer's psychobiology as an intellectual precursor of the biopsychosocial approach (1977, pp. 134-135). Meyer, a Swiss-American Psychiatrist influential in the first half of the Twentieth Century, intended by the "psychobiological" treatment model,

> undivided and direct attention to the person and to the function, health and efficiency of the person as a living organism…[in psychobiology] we study facts (a fact is anything which makes a difference) for what they mean in actual life, and by that we mean the life of a 'somebody.' He is to us an organism with a life history, a biography (Meyer, 1948, pp. 434-436).

Thus, the influence of Meyer's model consisted in his emphasis of integrative treatments and therapeutic holism.

Grinker, a neurologist and psychiatrist, was equally committed to holism, arguing against unmethodical eclecticism and working to resist the limitations of reductionism (Grinker, 1964). To this end, he "coined the term 'biopsychosocial' and emphasized its link to the then popular biological paradigm of 'general systems theory', a holistic view that saw reductionism as unscientific" (Ghaemi, 2006: 620). For Grinker, the mental health field in general, and psychiatry in particular, is,

> a conglomerate of many sciences involved in the study of human behavior, including biological, psychological, and social sciences. Since man is a biopsychosocial creature, psychiatry must include these sciences as part of the total system characterized by whatever variables are in focus at the time (Grinker, 1976: 211).

Grinker argued actively for a "struggle for eclecticism" that intended to overcome the limitations of psychoanalytic psychiatry (despite having been trained by Freud himself, Grinker took a circumspect view of the state of psychoanalysis)(Grinker,

1964). By consequence, Grinker intended to emphasize the need for a biological dimension in psychiatry, to counterbalance prevalent psychodynamic methods.

Contrastingly, for Engel, the biopsychosocial model was a means to emphasize the importance of psychological and social aspects in the treatment of even the most apparently physiological diagnoses. As such, in Engel's model, not just mental health professionals (Engel himself was a psychiatrist), but physicians across specializations must attend to individuals as they exist—as a biological, psychological *and* social entities. To this effect, a practitioner must, "take into account the patient, the social context in which he [sic.] lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the healthcare system. This requires a biopsychosocial model" (Engel, 1977, p. 132). Like Grinker, Engel deployed systems theory as a foundation for the biopsychosocial approach (Engel, 1980, p. 536). By employing a systems approach, Engel argued, the healthcare physician could integrate all relevant system levels. This was the basis upon which Engel argued explicitly against the application of a reductive biomedical treatment model. "An inclusive [biopsychosocial] approach," he wrote

> with consideration of all the levels of organization that might possibly be important for immediate and long-term care, may be contrasted with the parsimonious approach of the biomedical model. In that mode the ideal is to find as quickly as possible the simplest explanation, preferably the diagnosis of a single disease, and to regard all else as complications, 'overlay,' or just plain irrelevant (Ibid. 538).

Overall, Engel's articulation of the biopsychosocial approach has had ranging influence and has become, arguably, a dominant standard in the health sciences, and specifically in sex therapy field (though the scope of its actual implementation in clinical sex therapy practice is a point of debate, as described above).

Even before Engel's influential work, the substance of the biopsychosocial model had taken shape in the sex therapy field. In sex therapy, we can trace the biopsychosocial model back to Masters and Johnson's 1970 work *Human Sexual Inadequacy*. Masters and Johnson illustrated that sexual dysfunctions could originate in the "biophysical" or "psychosocial" spheres and that, irrespective of the point of origination, any dysfunction would surely elicit psychological effects (Masters & Johnson, 1970). "The psychosocial context within which feelings are perceived and the biophysical condition of the perceiver," they wrote, "characterize the sensory

experience and give it import" (Masters & Johnson, 1970, pp. 75-76). "Ultimately," they went on to explain, "it is the interdigital response patterns of the psychosocial and the biophysical systems and the individual characteristics of the men directly involved that predicate sexual survival or failure" (Masters & Johnson, 1970, p. 145).

This framework has a number of clear implications for research and therapy. First, the model indicates that sexual functioning depends upon a functional interaction between the biophysical and the psychosocial dimensions of sexual response; a failing in either structure will have an impact on *both* (biophysical and psychosocial) structures. By extension, treatment must account for and address both spheres. According to this "concept of the dual systems of influence operant at all times in perception and interpretation of sexual stimuli," Masters and Johnson explained, "the two systems of influence, the biophysical and the psychosocial structures, produce varying degrees of positive or negative input during opportunities for sexual expression" (Masters & Johnson, 1970, p. 202). Although their terminology differs somewhat from the singular term, "biopsychosocial," the conceptual bases of the biopsychosocial approach are clearly anticipated in Masters and Johnson's early work.

Recently, Perelman has expanded upon Masters and Johnson's concepts, through his "sexual tipping point™" conceptualization of sexual functioning (Perelman, 2006a, 2006b). This model schematizes sexual functioning and response biopsychosocially, indicating that a complex array of psychosocial and behavioural issues can either facilitate or inhibit sexual functioning; similarly, physiological and organic issues can enable or inhibit sexual functioning. According to the sexual tipping point™ concept, physiological and organic, and psychosocial and behavioural factors combine to either enable excitation and response, or inhibit sexual functioning and create a non-response condition. The sexual tipping point itself is "the characteristic threshold for an expression of sexual response" (Perelman, 2006b, p. 1007). This is a dynamic threshold, which varies between individuals and within an individual in different sexual episodes. It is important to note that the sexual tipping point™ model schematizes the aetiologies of male sexual dysfunctions as multifactorial and as necessitating multimodal treatment systems.

While it is difficult to delineate a complete list of possible causal variables, McCabe et al. provide the following non-comprehensive list of psychosocial factors which may contribute to a patient/client's sexual problems:

> i) patient variables such as performance anxiety and depression; (ii) partner variables such as poor mental or physical health and partner disinterest; (iii) interpersonal nonsexual variables such as quality of the overall relationship; (iv) interpersonal sexual variables such as the interval of abstinence and sexual scripts; and (v) contextual variables such as current life stresses with money or children (McCabe et al., 2010, p. 333).

To this, we can add a wide range of possible physiological factors, including: lower urinary tract symptoms (Elliott et al., 2004), diabetes (Corona et al., 2004) et al. 2004), cardiovascular disease (Reffelmann & Kloner, 2006), prostatectomy and iatrogenic effects of androgen deprivation therapy (Walsh, 2000), hypogonadism (Heaton & Morales, 2006) and substance abuse (Johnson et al., 2004). The conventional diagnostic framework holds that these pathogenic factors contribute to sexual dysfunction by disrupting the sexual response cycle—the ideal sequence of physiological response to sexual stimuli—a theory discussed at greater length in chapter 7 (Basson, 2001; Kaplan, 1974b, 1979; Levin, 2008; Masters & Johnson, 1966; Perelman, 2006b).

3.4.2. Biological Factors Implicated in Male Sexual Dysfunction

While the biogenic factors in sexual dysfunction are generally beyond the scope of this research project, practice guidelines indicate that it is incumbent on psychosexual therapists to develop and maintain multidisciplinary knowledge, which includes a coherent understanding of the key biological factors in sexual function and dysfunction (Binik & Hall, 2014). Consequently, it is worthwhile to briefly enumerate the primary biological factors in male sexual dysfunction that sex therapists may need to consider. In many cases, physical health factors (i.e. diet, exercise, etc.) correlate positively with indices of sexual health and functioning, and research suggests that lifestyle and health status overall are strong predictors of physically-based sexual problems (Meng Tan, Fah Tong, & Ho, 2012). In the diagnosis of male sexual dysfunction, research suggests, patients/clients should undergo physical testing to identify possible causal/contributing physiological factors (DeRogatis & Balon, 2009; La Rochelle & Levine, 2006; Wincze & Carey, 2001). This physical testing is considered an essential component of a comprehensive biopsychosocial intake and, as such, clinical guidelines recommend that it be conducted at the beginning of the assessment process (Berry & Berry, 2013a). This

section outlines some of the primary biological factors known to underlie male sexual dysfunction.

Research has shown that medication side effects are amongst the most common physical causes of sexual dysfunctions (McCarthy & McDonald, 2009b). Although the SSRIs' role in erectile dysfunction appears to be the most widely researched drug-aetiology in male sexual dysfunction, it is well established that impairment of sexual functioning is linked to a variety of pharmacological agents (both psychotropic and non-psychotropic), which can inhibit the entire sexual response cycle or one of its phases (Balon, 2009; Crenshaw & Goldberg, 1996; Segraves & Balon, 2003). Recreational drugs (including alcohol, cocaine, heroin, marijuana and nicotine) have also been associated with sexual dysfunction, particularly under conditions of prolonged or chronic use (Horvath, Calsyn, Terry, & Cotton, 2007; Palha & Esteves, 2008). Additionally, exposure to workplace toxins (e.g. manganese, stilbene, nitrous oxide, carbon disulfide) has been implicated in sexual dysfunction (Balon, 2009: 106; Segraves and Balon, 2003). *DSM-IV-TR* accounts for foreign substances' inhibiting effect on sexual function with the category of "substance induced sexual dysfunction" (pp. 562-565), which "may involve impaired desire, impaired arousal, impaired orgasm, or sexual pain. The dysfunction is judged to be fully explained by the direct physiological effects of a substance (i.e. a drug of abuse, a medication, or toxin exposure)" (p. 562). This category of dysfunction highlights the importance of physical assessment in the sexual dysfunctions.

DSM-IV-TR and *DSM-5* caution that in some instances of apparent substance/medication-induced sexual dysfunction, in reality the dysfunction is due to an underlying medical condition (often the condition being treated by a pharmacotherapy, or a comorbidity thereof) (American Psychiatric Association, 2000, p. 558; 2013, pp. 446-450). To encompass such cases, *DSM-IV-TR* includes the category of "sexual dysfunction due to a general medical condition," which "is the presence of clinically significant sexual dysfunction that is judged to be due exclusively to the direct physiological effects of a general medical condition" (p. 558), though this category has been omitted from *DSM-5*. A wide range of medical conditions can contribute to sexual dysfunctions. Lower urinary tract symptoms (LUTS), for instance, are commonly associated with sexual dysfunction, in particular ED (Stevenson & Elliott, 2009). Although there is a positive correlation between age and both ED and LUTS, it has been shown that there is an independent correlation

between ED and LUTS (Rosen, Giuliano, & Carson, 2005). Research into the pathophysiology of LUTS and ED is ongoing, and no clear causal sequence has yet been conclusively determined (Ibid. 828). Cardiovascular diseases are also causally linked with sexual dysfunction, especially ED, by virtue of reduced vascular efficiency and psychological correlates, in particular anxiety and depression (Denman, 2004; Goldstein, 2000). Diabetes, comparably, is linked to sexual dysfunction through arterial and nerve damage; "diabetic ED," Malavige and Levy illustrate,

> is multifactorial in aetiology and is more severe and more resistant to treatment compared with nondiabetic ED. Optimized glycaemic control, management of associated comorbidities and lifestyle modifications are essential in all patients. Psychosexual and relationship counseling would be beneficial for men with such coexisting problems (Malavige & Levy, 2009, p. 1232).

Obesity has also been shown to reduce sexual functioning, especially erectile functioning, in men, particularly through the diminution of serum testosterone, and increase in the likelihood of sleep apnoea (which is itself associated with ED) (Wylie, 2008).

Decreased androgen levels, increased prevalence of comorbid diseases (i.e. the aforementioned), and in some cases sedentary lifestyle, are considered to be amongst the correlative causes of sexual dysfunctions associated with older age groups (Rosen, Wing, et al., 2005). While decreases in sexual functioning are seen as an unavoidable part of the aging process, Araujo et al. note,

> it is unknown whether declines represent universal changes that are independent of disease and environmental factors (i.e., part of the aging process) or whether observed declines are due to factors that are associated with aging such as weight gain, comorbidity and medication use but which are not intrinsic to chronological aging itself (2004: 1507).

Overall, biological age correlates with a general diminution of sexual functioning, although some researchers hold there may higher prevalence of premature ejaculation amongst younger clients in certain clinical samples (Laumann et al., 1999; Schiavi, 1990).

Due to physical changes throughout one's lifespan McCarthy and colleagues argue for a popular shift in conceptions of sexuality, away from a "performance-based" model towards an "intimacy-based" model (McCarthy & Fucito, 2005; McCarthy & McDonald, 2009b; Metz & McCarthy, 2007). "Realistic, age

appropriate sexual expectations," Metz and McCarthy assert, "are essential for sexual satisfaction" (2007: 355). Metz and McCarthy also emphasize the importance of "relaxation" as an intervention for biogenic sexual dysfunctions (Ibid. 356). Relaxation as a therapeutic technique is an apparent node between the physiological and psychological aspects of sexual functioning. Overall, it is broadly understood that sexual dysfunction is often exacerbated and even perpetuated by psychological issues, even when the primary dysfunction inherently biogenic.

3.4.3. Psychological Factors Implicated in Male Sexual Dysfunction

Within the realm of psychotherapy, research suggests that an exclusive treatment targeting the sexual dysfunction alone is often impossible. "Clients," Firth and Mohamad state, "rarely present with a simple, focal problem; often this is embedded in complex historical and contemporary issues" (2007, p. 222). Like biogenic causes of sexual dysfunction, psychogenic aetiologies can entail significant psychopathological comorbidity (Stevenson and Elliott, 2009). In practice, a substantial number of clinicians argue that sexual dysfunctions are not pathologies in their own right, but rather symptomatologies characterizing a—potentially complex—set of psychological and relational factors. This conceptualization is discussed at greater length in chapters 7 and 8. Here, it is important to note that current research and clinical guidelines recommend that psychotherapists evaluate the interrelationship between a client's sexual dysfunction, his cognitions and behaviours, and his affective state (Montorsi, Adaikan, et al., 2010; Wincze & Carey, 2001). In particular, the assessment process must account for the individual's general psychological profile, and the possibility of other diagnoses. While it is not possible to provide a comprehensive overview of all relevant psychological factors here, this section outlines some of the most significant psychological and affective factors that are understood to cause, contribute to, or co-occur alongside the sexual dysfunctions.

Sexual dysfunctions are known to be associated with a range of other psychopathological states. However, while many theorists traditionally inferred a direct causal relationship between conditions such as depression, or anxiety, and sexual dysfunction (Kaplan, 1974; Masters, Johnson and Kolodny, 1982), it is often unclear if these are, in fact, causal relationships, or which is the operant direction of causality. Current research suggests that these types of conditions *can* cause or exacerbate sexual dysfunctions, but that there may often be a relationship of mutual

enforcement between sexual dysfunction and related psychological problems (Stevenson and Elliott, 2009). While it is impossible to develop a universal aetiological model for the sexual dysfunctions, based on current research, common contributing factors, and general causal trends are identified in the current literature (DeRogatis & Balon, 2009; Stevenson, 2009; Stevenson & Elliott, 2009). These include: depression, anxiety, substance abuse/dependence, acute or chronic stress, personality traits, and other diagnosable mental disorders. In cases of psychopathological comorbidity, it is recommended that the clinician consider whether other issues need to be addressed or treated before the dysfunction itself can be dealt with. Substance dependence, for instance, illustrates the utility of the biopsychosocial model by virtue of its clearly defined biological, psychological and social influences on sexual functioning; within the literature, there is a consensus that in most cases substance abuse must be dealt with before sexual dysfunction can be treated effectively (Perelman 2006b; Wincze and Carey, 2001; Balon, 2009).

Research also indicates that there are significant correlations between sexual dysfunction and a man's affective state, and dysfunction is commonly associated with anxiety and depressive affect (Derogatis and Balon, 2009). Likewise, sexual dysfunction is understood to be correlated with personality factors, such as poor self-image, lowered self-esteem, and apprehension of negative judgment (McCabe et al. 2010). These variables may be considered as potential predisposing, precipitating or maintaining factors in the sexual dysfunction (Hawton, 1982, 1985). Anxiety, for instance, can be framed as predisposing, precipitating *and* perpetuating sexual dysfunctions (Martin et al., 2012; McCabe et al., 2010; Telch & Pujols, 2013; Toates, 2009). Perelman addresses anxiety; noting the interplay between biogenic precipitation and psychogenic maintenance of erectile disorder, he states, "anxiety may exacerbate even a mild organic situation into a seemingly total deficit. The manifest deficit frequently exceeds the actual organic impairment" (Perelman, 2006b: 105).

The role of anxiety in sexual dysfunction was particularly salient in the work of early sex therapists (Kaplan, 1974a, 1974b; Masters & Johnson, 1966; Masters & Johnson, 1970). Masters and Johnson, for instance, conceived of anxiety as a primary causal factor in sexual dysfunction. In addition to straightforward performance anxiety (1982: 368), they held, "fears of pregnancy, venereal disease, rejection, losing control, pain, intimacy, and even success can also block the pathways of sexual response" (Ibid.: 379). Whatever the cause, in Masters and

Johnson's view, anxiety generally led to a dissociative state, called "spectatoring," in which the individual's physical responses are stifled by dissociation from sexual activity and detachment from sexual stimulus (Masters & Johnson, 1966; Masters, Johnson & Kolodny, 1982; Althof et al. 2005). More recently, researchers have argued that the presence of anxiety does not, in itself, suggest a direct/linear causal process (Althof et al. 2005). Instead, researchers suggest that it is not anxiety per se, but anxiety wedded to negative performance ideation, that contributes most significantly to sexual dysfunction (Wincze & Carey, 2001). Citing Barlow (1986), Althof et al., for instance, suggest that anxiety may not inhibit sexual performance directly, but may contribute to sexual dysfunction through "cognitive interference":

> what appears to distinguish functional from dysfunctional responding is a difference in selective attention and distractibility. What sex therapists consider performance demand, fear of inadequacy, or spectatoring are all forms of situation-specific, task-irrelevant, cognitive activities which distract dysfunctional individuals from task-relevant processing of stimuli in a sexual context (Althof et al. 2005: 795).

While anxiety is amongst the most widely researched affective factors in sexual dysfunction, data indicate that there are numerous other psychoaffective variables that are comparably influential with respect to sexual function.

As Masters, Johnson and Kolodny noted, "guilt, depression, and poor self-esteem are encountered frequently in association with sexual dysfunctions. Sometimes, though, it is difficult to know which came first, the feeling or the dysfunction" (Masters, Johnson & Kolodny, 1982: 379-380). Perelman notes the comorbidity between depression and erectile dysfunction, and asserts that the "[sexual] history interview must 'parse out' whether the ED is causing depression or whether the depression and its treatments (e.g. selective serotonin re-uptake inhibitors) are causing the ED" (Perelman, 2006b: 114). Depressed patients appear more susceptible to other forms of sexual dysfunction as well; according to Bonierbale et al., 40%-50% of patients with clinical depression have some form of sexual dysfunction (2003). In addition to anxiety and depression, DeRogatis and Balon specify stress as a possible precipitant of sexual dysfunctions, and argue, "any strong negative affect state (e.g. anxiety, guilt, hostility) can be extremely disruptive to smooth, satisfying sexual function" (2009: 29). The influence of such negative affective states is addressed at length in chapter 8 (see especially sections 8.4-8.4.3).

3.4.4. Social Factors Implicated in Male Sexual Dysfunction

Published research indicates that interpersonal relationships and the social dimensions of sexuality are especially focal for sex therapists, with high priority being placed on a couples-counselling approach to sex therapy (Atwood, 1993; Atwood, Klucinec, & Neaver, 2006; Meana, 2010). Data from this study, on the use of a couples counselling approach, are described in chapter 5 (see especially sections 5.3-5.3.3). Here, it is important to note the core features of the couple therapy paradigm, as it is portrayed in the extant research literature. This therapeutic paradigm largely conceptualizes sex and sex therapy as a shared experience involving a man and his partner, apparently in sharp contradistinction to the biomedical model, which casts sexual dysfunction as a male biomechanical problem (Metz and McCarthy, 2005; 2007). The biopsychosocial model helps account for the social dimension of sexual functioning and sex therapy by acknowledging that a dysfunction may be an artifact of interpersonal issues—both sexual and non-sexual—in a relationship, and that its treatment generally requires cooperative effort between a man and his partner, or partners (Metz and McCarthy, 2007; Perelman, 2006).

The couple-therapy-oriented literature, however, often appears to presuppose that the client has a partner, and is often predicated on the assumption of a long-term and monogamous partnership. Additionally, traditional couple-oriented treatment models have been critiqued as largely heteronormative, as the majority of the work on couples sex therapy focuses on male-female partnerships, though recent work seeks to redress this perceived lack of alternative discourses (Barker & Langdridge, 2008, 2010b; Bigner & Wetchler, 2012). Further research is needed to determine the extent to which treatment principles designed for monogamous heterosexual couples can be generalized to in LGBTQ clients, clients in openly non-monogamous relationships, and single male clients. Irrespective of the client's relationship typology, this research project evaluates the hypothesis that therapists adherent to the biopsychosocial approach evaluate and treat the client's sexual problems with focused attention on socio-cultural and inter-personal context.

Systems theory has provided a useful framework, widely noted by research participants in this study, for understanding the social dimensions of sexual dysfunction (Hartmann & Waldinger, 2007; Rosen, Fisher, Beneke, Homering, & Evers, 2007). Systems theory holds that the system, for instance the interpersonal relationship, has *emergent properties*—qualities that make the system more than the

sum of its parts. This paradigm, therefore, casts the sexual dysfunction as one aspect of a set of complex, interconnecting relationship issues. Sexual problems may emerge in a self-perpetuating relational cycle, being caused by (often non-sexual) relationship problems, and in turn exacerbating these problems (Atwood & Klucinec, 2007; McCarthy & McDonald, 2009b). "In this view," Atwood and Klucinec write,

> one's demands may be the result of his or her sexual frustration and feelings of rejection. The other's anxiety may be a combination of sexual conflict, self-doubt about sexuality and/or fear of failure to please the partner. Thus, the important features of systems therapy included interrupting whatever cycle had been developed (2007: 62).

Extending this logic psychosocially, systems theorists acknowledge that any negative affect or social problem in the relationship (i.e. guilt over infidelity, resentment, unresolved conflict, etc.) can contribute to a sexually dysfunctional cycle (DeRogatis and Balon, 2009). Systemic sex therapy, therefore, aims to work with the interpersonal relationship and the systemic dynamics that predispose, precipitate, or maintain sexual problems (Hertlein, Weeks, & Gambescia, 2009; Hertlein, Weeks, & Sendak, 2009).

Social constructionism extends the critical sociological analysis of sexuality and sexual dysfunctions beyond the intimate relationship, enabling it to encompass broader socio-cultural factors (Atwood, 1993; Gagnon & Simon, 1973). By focusing on processes of "meaning-making," social constructionists seek to account for the role of the wider culture in shaping patients' views and experiences (Atwood, 1993: 116). According to Gagnon, individuals "script" their sexual behaviours, devising an imagined linear sexual scenario and narrative, through a dialectic of cultural symbolic systems, personal fantasy, and norms (1990). These scripts, profoundly influenced and shaped by cultural norms and values, actively form, and often constrain, individuals' sexual behaviour and expectations. According to Gagnon and Simon, there are three facets of scripting: narratives shaped by cultural scenarios that dictate an individual's understanding of social roles, standard interpersonal scripts entrenched in day-to-day interaction, and internal psychological scripts that an individual uses in defining their behaviours according to cultural protocols (1973). Scripting, therefore, is a psychosocial phenomenon that shapes both cognitive processes and behaviours.

Within the social constructionist model, Atwood asserts, sex therapy aims to influence the client's sexual scripts (Atwood, 1993; Atwood et al., 2006).

Specifically, it is held that through effective sex therapy a clinician can help the client to challenge and re-shape the meaning-making process by which he defines his sexuality, and his standards of sexual performance. "The dialectical relationship between individual realities and the socially constructed sexual meanings is the recurring focus of this therapy," Atwood and Klucinec write (2007, p. 67). In the couple therapy format, Atwood, Klucinec and Neaver advocate a system of analysis that examines a couple's "stories," including the story they hold about their history (i.e. how they formed their sexual meanings and scripts), the story of their present (i.e. how their scripts and systems of meaning are maintained), and the story of their future (how their scripts can evolve over time) (2006: 412-414). The main therapeutic goals are to: show the couple "that there are numerous scripts to choose from" (Ibid. 414), enable them to select scripts that are more conducive to relationship and sexual satisfaction, and to instil in the couple a belief that "sex can be a complex, vibrant system incorporating, and not limited to, learned rules, scripts, relationships, behaviors, sensations, thoughts, feelings, desires, identity, emotions and meanings of the past, present, and future" (Ibid. 416).

Metz and McCarthy also draw on the social constructionist model in advocating a couple-oriented sex therapy approach, suggesting that most couples troubled by sexual dysfunction can benefit from changing their sexual scripts (2007). Specifically, they recommend that male clients challenge their gender-consonant focus on sexual performance with a script that focuses on shared pleasure and intimacy. This psychosocial shift is the basis for the "good-enough sex model" (Metz & McCarthy, 2003, 2004, 2007). The overarching, and ultimate aim of sex therapy, Metz and McCarthy write, "must be the well-being of the couple…the primary aim of sexual therapies should be couple satisfaction," (2007: 353). In order to attain such satisfaction, it is widely held that a man and his partner must establish "realistic expectations" (Metz & McCarthy, 2003, 2004, 2007; Firth & Mohamad, 2007). In the "good-enough sex model" these realistic expectations are qualified (and quantified) by "a variable, flexible pleasure-oriented approach to couple sexuality, which involves an '85 percent approach' to intercourse and orgasm while validating alternative sensual and erotic scenarios" (Metz & McCarthy, 2007: 361).

In sum, research and clinical literature indicate that the dyadic relationship between a man and his partner—where such a relationship exists—may be the most significant social dimension of male sexual dysfunctions, for a majority of patients (Conradi, De Jonge, Neeleman, Simons, & Systema, 2011; Martin et al., 2012;

McCabe et al., 2010; Rosing et al., 2009; Rowland & Cooper, 2011; Wittmann, Foley, & Balon, 2011). Nonetheless, other social relationships, and social and cultural behavioural and identity scripts are also seen as exceedingly important to sexual functioning (Graham & Hall, 2012; Hatfield & Rapson, 2010; Pertot, 2006). This body of research also holds that social variables must be assessed and addressed psychosocially, considering the interaction between social and cultural pressures and expectations, relationship factors, and a man's psychological and affective state. In turn, the psychosocial aspects of sexual functioning must be evaluated vis-à-vis the man's physiological state, and in light of a comprehensive physiological assessment. "All three components," McCarthy and McDonald write, "biological, psychological, and social—are crucial to understanding the person, the illness, and individual, and couple sexuality…If one or more components are minimized, the result is likely to be a sex therapy failure" (2009b, p. 324). In short, the research considered here supports the recommendation that, in order to provide a maximally effective treatment for sexual dysfunction, therapists must consider each facet of the biopsychosocial paradigm.

3.5. Where Do We Go From Here? Building on the Contemporary Context

As chapter 3 has illustrated, the field of sexual science has evolved considerably beyond the pendular historical shifts between physiological and psychological theories and treatments described in chapter 2, as clinicians and researchers have worked to develop integrative, biopsychosocial treatment systems. However, this chapter also shows that the conflict between biological and psychological methods remains visible in the biomedical and pharmaceutical push and apparent tendencies towards "overmedicalization" (Waldinger, 2008). Recent and newly emerging research, in addition to highlighting the importance of biopsychosocial practice and care standards, underscores the need for further data on the role of psychotherapeutic interventions and techniques within the wider biopsychosocial field (Althof et al., 2014; Berry & Berry, 2014; Binik & Hall, 2014; Rowland, Tuohy, & Humpfer, 2014). Additionally, the more specific question, identified in chapter 1 remains—where do psychodynamic methods fit within the wider psychotherapeutic frame? The results of this research project, described in the following chapters aim to build on the research described above, and to help advance our understanding of the role of psychotherapeutic methods, specifically

psychodynamic theory and technique, within the biopsychosocial treatment of male sexual problems.

CHAPTER 4. RESEARCH OBJECTIVES AND METHODOLOGY

4.1. Introduction

Chapter 4 sets out the purpose and methodology of this research project. First, the objectives of the project are restated, including the underlying research questions and their importance within the research field. A description of how psychodynamic psychotherapy is conceptualized in this research project follows. The research methodology is then described, including a discussion of the two-part—quantitative and qualitative—survey used for data collection. Survey construction, pilot testing procedure, reliability and validity are discussed. The sampling methodology and estimated response rate of the survey are explained. Areas of research bias, and the measures used to control for this factor, are then addressed. The chapter concludes with an outline of the ethical considerations of this project, and the steps taken to ensure informed consent.

4.2. Research Objectives

There is a noted shortage of empirical research in the sex therapy field (McCabe et al., 2010). This relative scarcity is seen as one of the shortcomings of the discipline; evidence-based practice, Althof emphasizes,

> has become the gold standard for judging the efficacy of psychological or medical interventions…[but] Sex therapy treatment outcome studies can be characterized as uncontrolled, unblended trials; none meet the requirements for high-level evidence-based studies (2007, p. 234).[18]

More specifically, as stated in chapters 1 and 2, research on the current role of psychodynamic methods is significantly lacking.

As outlined in section 1 of this dissertation, research suggests that psychoanalytic and psychodynamic techniques were amongst the primary modalities used in the treatment of male sexual dysfunction through much of the 20th century

[18] Qualitative data from this research project appear to support Althof's (2007) assertion that the limited number of high quality outcome studies largely stems from the fact that sex therapy process research is a low priority for many funding bodies. Additionally, it is possible that the high emphasis on biomedical—especially pharmacological—treatments has obscured the need for research on psychotherapeutic treatments in this area.

(Berry, 2013b; Hartmann, 2009; Waldinger, 2006, 2013). However, it appears that two complementary trends have created a divide between psychoanalytic/psychodynamic psychotherapy and sex therapy research. First, Segraves suggests, sex therapy as a distinct clinical discipline "evolved from the tradition of behaviourism" putting it at odds with psychoanalysis from the start (1986, p. 485). This evolution is apparent in the work of Masters and Johnson, outlined in chapter 2 (1982, pp. 13, 383). Second, it has been argued that, amongst psychoanalytic and psychodynamic researchers and clinicians, attention to the role of sexuality has diminished over time. This "marginalization of sexuality in psychoanalytic theory and practice," Shalev and Yerushalmi write, has effectively limited psychoanalysis' sphere of influence over the treatment of sexual issues (2009, p. 343). In light of these factors, the current role of psychodynamic methods in contemporary sex therapy practice is largely unknown.

It has been suggested, however, that "therapists of the same orientation…differ widely in their processes" (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Najavits, 1997, p. 1; Najavits & Strupp, 1994), and that psychotherapists from different clinical/theoretical orientations may often show a marked resemblance in therapeutic style/technique (Larsson, Broberg, & Kaldo, 2013; Smith, Glass, & Miller, 1980). Relatedly, evidence in the wider psychotherapy field suggests many clinicians may use psychodynamic techniques implicitly, without identifying them as grounded in psychodynamic theory per se (Blagys & Hilsenroth, 2000; Shedler, 2010). Consequently, the first research question for this project is designed to test the hypothesis that psychotherapists in general, and sex therapy specialists in particular, regularly use psychodynamic methods in treating men's sexual dysfunctions—though they may not explicitly designate these techniques as 'psychodynamic'.

As stated in chapter 1, in the first instance, this research aimed to answer the question: *to what extent do psychosexual therapy specialists use psychodynamic techniques in treating men's sexual problems?* Despite long-standing, and well-documented, theoretical and clinical opposition between cognitive behavioural and psychodynamic psychotherapy, it has been argued that these two models may possess complementary strengths, both theoretically and technically (Westen, 2000). This research project is predicated on the hypothesis that, rather than competing methodologies, cognitive behavioural and psychodynamic methods may currently be employed conjunctively and integratively in sex therapy. This research project tests

this claim by identifying the key practices used by sex therapists in treating male sexual problems, and by differentiating psychodynamic and other techniques within this body of practice. The project then compares the degree to which sex therapists report using prototypical and distinctive psychodynamic techniques versus prototypical and distinctive cognitive behavioural techniques in their work with male clients.

There is a significant body of evidence indicating that psychotherapeutic techniques, in general, are efficacious in the treatment of a range of sexual problems (Melnik, Soares, et al., 2008a; Melnik, Soares, & Nasselo, 2008). However, as indicated above, evidence for the integration of psychodynamic methods in the psychotherapeutic treatment of men's sexual problems is much more limited. On this basis, a mixed-method survey has been used to investigate how psychodynamic practices may fit within sex therapy as a distinctive clinical specialty.

A number of secondary aims (described also in section 1.2.1.) also guide this research project. Broadly, this research project aimed to determine how psychodynamic techniques are situated within the wider clinical field, using a number of measures of clinical practice, including respondents' reported use of biopsychosocial methods, combinative techniques, goal-setting, interpretations of aetiology, perspectives on diagnosis, etc. This dissertation presents data on:

- the ways in which survey respondents conceptualize and use the biopsychosocial model, and integrative practice, including couple therapy (chapter 5),
- the diagnostic and assessment protocols—including psychodynamic methods—psychosexual therapists use with male clients (chapter 6),
- the methods used in establishing clinical goals and developing a case formulation, including the strategies that may be employed in working with diverse client groups (chapter 7),
- the ways in which sex therapy specialists and psychotherapy generalists conceive of and assess the aetiology—in particular psychodynamic factors—of male sexual problems (chapter 8), and
- the place that psychodynamic versus CBT techniques play in the treatment of male sexual dysfunction, including the most salient strategies, links to psychodynamically-informed therapeutic models, and strategies for the integration of psychodynamic methods in clinical work (chapter 9).

The overarching aim of this research project is to advance the discipline by

evaluating the role that psychotherapeutic methods, and specifically psychodynamic psychotherapy theory and techniques, play in the treatment of men's sexual dysfunctions. The novel contribution of this research is indicated by the increasing call for evidence-based, multi-modal treatment paradigms in the contemporary health sciences, and the sexual health field in particular (McCarthy & Fucito, 2005; Metz & McCarthy, 2005; Mezzich & Hernández Serrano, 2006; Perelman, 2005b), and in light of recent research indicating the value of integrative and biopsychosocial methods in the treatment of sexual problems in general, and male sexual problems specifically (Berry & Berry, 2013a, 2014).

4.3. How Psychodynamic Techniques are Defined in this Research Project

This research project evaluates a contemporary model of psychodynamic psychotherapy, which holds a number of tenets common to psychodynamic and psychoanalytic psychotherapies. Within this research, psychodynamic practice is conceptualized according to a set of core techniques of psychodynamic psychotherapy identified in prior research by Ablon & Jones, Blagys & Hilsenroth, Masters & Johnson, and others, and confirmed by subject matter experts (Ablon & Jones, 1998; Ablon, Levy, & Katzenstein, 2006; Allen, 2006; Blagys & Hilsenroth, 2000, 2002; Drummond & Kennedy, 2006; Hobbs, 2006; Masters & Johnson, 1966; Masters & Johnson, 1970, 1975; Masters et al., 1982; Shedler, 2010).

The model of psychodynamic practice evaluated is seen, in the first instance, as including a clinical focus on unconscious processes as a foundation for psychotherapeutic work. As Higdon writes, "an acknowledgment that our thinking and behaviour is affected by processes of which we are not fully conscious" is a primary tenet of psychodynamic theory, and examination of unconscious factors/processes is widely seen as a central characteristic of psychodynamic and psychoanalytic psychotherapies (Bateman et al., 2010; Higdon, 2012, p. 9). Examination of unconscious factors is a central psychotherapeutic technique evaluated here.

Additionally, focus on early life events' influence on the individual's psychology, and focus on the influence of the individual's family of origin, including parental/caregiver relationships is considered to be a defining feature of psychodynamic work (Gabbard, 2005). Specifically, it is held that psychodynamic work involves helping the client to use material from the past to gain insight into the present (Huprich, 2009); this psychodynamic principle's role in sex therapy practice

is also evaluated in this study. Moreover the focus on early life, family of origin, and parental factors—especially from a developmental perspective—is seen as one of the common features shared between psychodynamic theory and attachment theory (Cassidy & Shaver, 2008; Clulow, 2009). Consequently, psychosexual therapists' tendency to focus on early life and family of origin factors, and the role of attachment theory in research participants' clinical work, are evaluated in this study.

Within this framework, increasing the client's *insight* is seen as a core goal of psychodynamic psychotherapies. As Huprich suggests, the patient's insight may be gained/increased through "the interpretations or suggestions of the therapist", or (for more relationally-oriented psychotherapists) "as a product of mutual discovery that arises from the meaningful relationship that develops between patients[/clients] and therapists" (2009, pp. 105-106). This research project has sought to determine the level of emphasis therapists place on new insight—in particular insight into the relationship between past and present, the relationship between self and others, and the conscious and unconscious influence of these factors over current sexual and relational functioning.

Additionally, Huprich has identified "improved reflective functioning" (2009, p. 105) as a foundational goal in psychodynamic psychotherapy. Notably, researchers working in the field of mentalization-based therapy have identified reflective functioning as a central measure of mentalizing (Bateman & Fonagy, 2012; Fonagy & Target, 1997). This research project addresses this area, evaluating the role of reflective functioning as a clinical goal in psychosexual therapy, and considering the prospective value of mentalization-based therapy—a model strongly informed by attachment theory—in the treatment of male sexual dysfunction.

Also central to both psychodynamic psychotherapy and attachment-theory is the conception of the client-therapist relationship as a vehicle for change, and as a focus for clinical discussion (Cabaniss, Cherry, Douglas, & Schwartz, 2011; Higdon, 2012). Ablon and Jones underscore this point, identifying discussion about the therapeutic relationship as a prototypical psychodynamic psychotherapy technique (1998). Further, the concepts of transference and counter-transference—core elements of psychodynamic work—are seen as inherent within the psychotherapeutic relationship. It is noted that working with these processes entails explicit discussion of the psychotherapeutic relationship (Bateman et al., 2010; Higdon, 2012). Consequently, the degree to which psychosexual therapists explicitly discuss the

therapy relationship, including transference processes, is evaluated in this study, as a central psychodynamic technique.

Finally, it is of note that, for many psychosexual therapists, the process of gaining insight into the ways in which the past influences the present (especially unconsciously), may be inherently linked with the objective of increasing understanding of the aetiology of the client's sexual dysfunction/problem, and the current defences or resistance the client might manifest against psychological change (Huprich, 2009). This study, therefore, evaluates research participants' conceptualization of the aetiological factors underlying clients' sexual problems, including the potentially repressive functions of early life and developmental experience—and the emphasis clinicians place on the client's increased understanding of these aetiological factors as a vehicle for psychotherapeutic change.

The characteristics of psychodynamic psychotherapy evaluated in this research are summarized in table 4.1.

Table 4.1
Characteristics of Psychodynamic Psychotherapy Evaluated in this Research Project

- Focus on unconscious processes
- Emphasis on gaining insight into unconscious/unrecognized processes as a core component of psychotherapeutic change
- Emphasis on the importance of understanding the aetiology of sexual problems—including unconscious aetiological processes
- Emphasis on repression as a contributing factor in sexual problems
- Focus on early life events' influence on current life experiences and psychosexual problems
- Focus on the influence of family of origin, including parental relationships
- Link to attachment theory
- Link to mentalization-based theory and practice
- Improved reflective functioning (RF) seen as a core goal
- Emphasis on the relationship between the therapist and client (especially as an archetype for outside relationships, and/or as a vehicle of psychological change)
- Examination of transference and counter-transference
- Identification of client's unconscious defences and resistance to change

4.4. Research Methodology

In order to evaluate these factors and address the research questions outlined above, an empirical survey of sex therapists, psychotherapists, and subject experts in the sex therapy field was conducted. This two-part survey consists of:

1) a quantitative online questionnaire administered to sex therapy specialists and generalist psychotherapists who treat male sexual dysfunction, and
2) an interview-based study of sex therapists and subject experts.

The questionnaire was devised primarily to address the first research question—to what extent do sex therapists use prototypical and distinctive psychodynamic techniques in the treatment of male sexual dysfunction? The questionnaire was designed to quantify the degree to which respondents use prototypical and distinctive psychodynamic and CBT techniques, respectively, in the treatment of male sexual dysfunction.

The verbal interviews were used to gain a broader and more detailed qualitative picture of sex therapy specialists' clinical practice, including the dominant theories and accepted practices of sex therapy, as understood by clinicians and subject experts in the area. The qualitative data, gained from the interviews, were used to address the second research question—how might psychodynamic techniques best be used in the treatment of male sexual problems? Interviews evaluated the role that psychodynamic methods currently play, and how clinicians understand their use of psychodynamic theories and techniques, within the contextual frame of wider treatment practices. In addition to the explicit and intentional use of psychodynamic methods, interview data illuminate a number of implicit and/or unrecognized ways in which psychosexual therapists may use psychodynamic theory and technique.

4.4.1. Questionnaire: Purpose and Construction

As stated above, the questionnaire's primary purpose is to examine the degree to which psychotherapists use *prototypical and distinctive psychodynamic techniques* and *cognitive behavioural techniques*, respectively, in the treatment of men's sexual dysfunctions. These data shed light on the common assertion—noted above—that sex therapy is principally cognitive behavioural in orientation. The questionnaire's secondary purpose is to provide data on the other key areas of study, identified in the secondary research aims listed above (see especially sections 4.2.1., 1.2.1. and 1.2.2.); consequently the questionnaire also inquires about respondents' use of the biopsychosocial model, couple therapy frameworks, methods used in setting goals,

views of diagnostic practice, etc.

The primary point of comparison is between sex therapy specialists and psychotherapy generalists. By comparing these two groups, data from the questionnaire may help indicate the distinctive features of sex therapy, and the degree to which sex therapists, as opposed to psychotherapy generalists, use particular techniques.

The complete questionnaire (provided in appendix A) is comprised of three question subsets:

1) *demographic questions*, including:
    - professional title/designation (i.e. psychologist, psychiatrist, etc.)
    - country of practice
    - employment capacity (i.e. private practice, public health services, etc.)
    - years of experience working in treatment of male sexual dysfunction, and
    - number of patients treated.
2) *general practice questions*, including:
    - how 'success' is defined in the respondent's clinical practice
    - questionnaires and psychometric devices used
    - view on the importance of the biopsychosocial model of therapy
    - use of the biopsychosocial model of therapy, overall and with most recent patient
    - estimated use of integrative/multidisciplinary practice (i.e. collaboration/consultation with other healthcare providers), overall and with most recent patient
    - use of couple-counselling approach, in general and with most recent relevant patient
3) quantitative *treatment paradigm* questions about the respondent's use of prototypical psychodynamic and CBT techniques.

The majority of questions are quantitative, and use a five point Likert scale to measure the degree to which respondents report using particular clinical techniques. Responses range from 1="not at all," to 5="to the maximum possible degree," or from 1="never," to 2="always".

As indicated above, this research project focuses on clinical practice, and takes clinicians as research participants. Published research by Westen and Shedler (2007; 1999a, 1999b) provided a model for this method of inquiry in psychodynamic research. Westen and Shedler used clinician surveys to develop the Shedler Westen Assessment Procedure (SWAP-200), a clinical tool for the diagnosis of personality disorders. Additionally, in a 1999 study that sought to investigate diagnostic prototypes used by clinicians, Shedler and Westen asked the majority of clinician respondents to use the SWAP-200 "to describe a current, actual patient" (1999: 264). By studying clinicians' practices, and by focusing on specific clinical examples, they contend, researchers can "*harness* clinical judgment" and practitioners' expertise as a foundation for research that is "both clinically relevant and empirically rigorous" (Shedler & Westen, 2007, p. 42). One significant limitation of most self-report methodology is that it asks clinicians to estimate their treatment practices; such estimates, Shedler and Westen hold, which may often be biased, or misaligned with clinicians' actual practices.

To help counter this limitation, the questionnaire followed Shedler and Westen's model by asking respondents to report on the techniques they used in the *most recent, actual case* of men's sexual dysfunction they treated. Asking participants to respond on the basis of an actual, specific client was chosen over a general questioning method (in which respondents would be asked to estimate their overall use of specific techniques/methods), in order to help control against estimator bias. The utility of asking respondents to describe a specific, actual patient/client, Shedler and Westen hold, is that this enables clinicians "to [describe] their patients and not idealized prototypes" (1999a, p. 270). Additionally, Shedler and Westen have found clinicians' reports about a single, specific client to be highly generalizable to clinical practice (1999a, 1999b). Consequently, they hold that reporting on a specific, actual client may provide a more representative account of clinical experience than reporting a general estimate of clinical practice. In responding to general questions about their usual therapeutic techniques, practitioners may be biased by treatment philosophy; for instance respondents may answer in accordance with a professed treatment model, rather than indicating what they actually do in the clinical setting. Likewise, in asking generally about practitioners' methods, there is a risk of recall bias, as practitioners' preferred methodologies may change over time.

4.4.2. Questionnaire: How Prototypical and Distinctive Psychodynamic and Cognitive Behavioural Therapy (CBT) Techniques were Defined

To develop questions assessing prototypical and distinctive psychodynamic and CBT techniques, a combination of 1) prior research on paradigmatic psychotherapy and sex therapy techniques (especially, work by Ablon and Jones, and Masters and Johnson), and 2) feedback from subject experts was used (Ablon & Jones, 1998; Allen, 2006; Drummond & Kennedy, 2006; Hobbs, 2006; Masters & Johnson, 1966; Masters & Johnson, 1970, 1975; Masters et al., 1982; Shedler, 2010). First, the work of Ablon and Jones, which defines a set of prototypical psychodynamic and CBT techniques, based on a survey of subject experts, was used as a source. Ablon et al. surveyed clinical practitioners, using a Q-sort methodology to "develop prototypes of psychodynamic and cognitive-behavioral therapy" (Ablon & Jones, 1998, p. 71). The prototypical psychodynamic and CBT techniques identified in the research of Ablon et al. were a primary source for the treatment paradigm questions in the questionnaire. Additionally, behavioural sex therapy techniques identified by Masters and Johnson (1982, 1975, 1970 1966), and cognitive behavioural techniques identified by Allen (2006), and Drummond & Kennedy (2006), were used in developing questions measuring respondents' use of prototypical cognitive behavioural methods.[19] In addition to Ablon and Jones (1998), prototypical psychodynamic psychotherapy techniques were developed from research by Hobbs (2006), Shedler (2010), and Blagys and Hilsenroth (Blagys & Hilsenroth, 2000, 2002). (The questions considered prototypical of psychodynamic and cognitive behavioural techniques, respectively, and the research sources from which each question was adapted, are indicated in the full copy of the questionnaire, provided in appendix A).

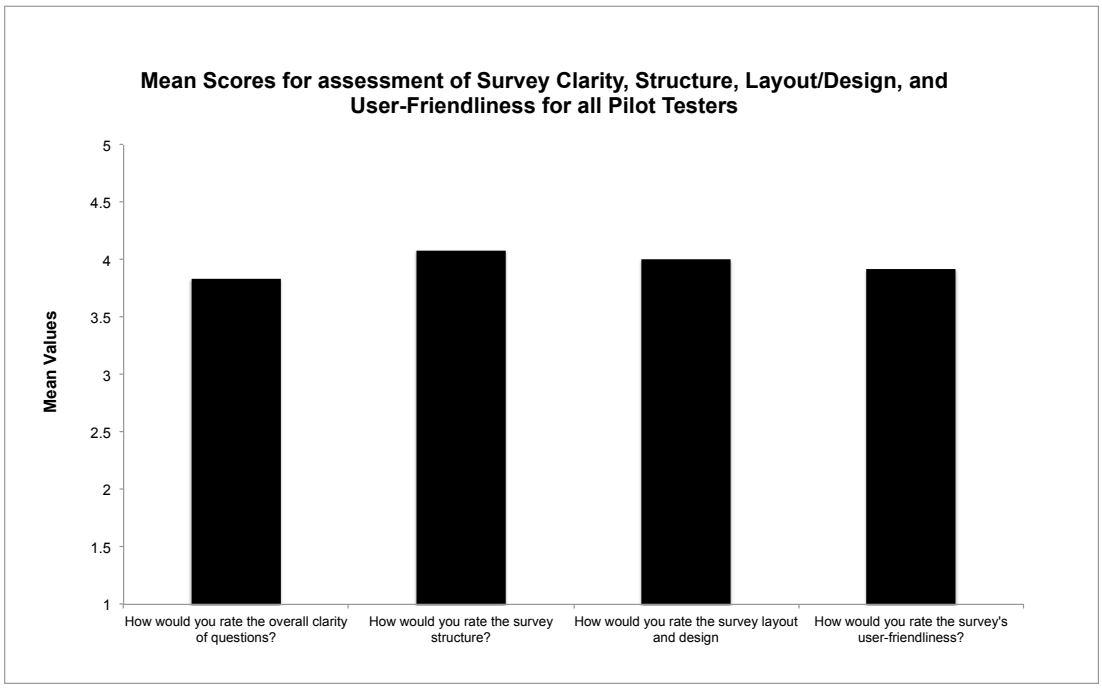
4.4.3. Questionnaire—Pilot Testing

Pilot testing with subject area experts was used to confirm the representativeness and validity of the prototypical psychodynamic and CBT techniques defined in this study, as well as the reliability of the questionnaire. First, the questionnaire was completed by twelve licensed psychotherapists with

[19] Due to the inclusion of cognitive behavioural techniques developed by Masters and Johnson, a number of the CBT techniques evaluated are sex therapy specific, whereas the psychodynamic techniques were more general. It is noted that this may increase the likelihood that sex therapy specialists (who are more likely to have training in, and exposure to, these sex therapy specific CBT techniques) would score higher on the CBT measures, relative to their psychotherapy generalist counterparts.

experience in the treatment of male sexual dysfunction, who analyzed its validity and accuracy in testing the specific concepts measured, its completeness in testing psychotherapists' reported practices, and the overall structure, layout and usability of the instrument. Pilot participants were instructed about the purpose of the survey, including the techniques evaluated, prior to completing the survey (the introductory information page given to pilot testers is provided in appendix B). After completing the test, pilot testers were asked a series of questions (provided in appendix C) to rank the survey on its overall level of clarity, structure, survey layout and design, using a five-point Likert scale, ranging from "unclear" to "clear". Additionally, they were asked to rank the survey on user-friendliness, using a five-point Likert scale, ranging from "difficult to use" to "easy to use". Figure 4.1 illustrates the mean scores for pilot testers' assessment of the clarity ($M = 3.83$), structure ($M = 4.08$), layout/design ($M = 4.00$), and user-friendliness ($M = 3.92$) of the survey. Overall, the majority of respondents ranked the survey as "clear" and as "fairly easy to use", indicating good instrumental validity for the survey device.

Figure 4.1 Mean Scores for assessment of Survey Clarity, Structure, Layout/Design, and User-Friendliness for all Pilot Testers



In addition, pilot testers were asked to assess whether the length of the questionnaire was appropriate; the majority (91.7%) of pilot testers answered affirmatively, stating that the length of the questionnaire was appropriate.

For the questionnaire, the main types of validity concerned are: "content" validity, instrument validity, and "face" validity (Langdridge & Hagger-Johnson, 2009).[20] Content validity—the appropriateness and completeness of items in the survey—and instrument validity—the extent to which the instrument measures what it aims to—were ensured through pilot testing by psychotherapy experts.

Pilot testers were also asked to assess the instrumental validity of the survey in measuring prototypical cognitive behavioural therapy and psychodynamic psychotherapy techniques respectively. This was posed as an open-ended question for qualitative feedback; eleven pilot test participants responded to the question. The majority of these respondents (81.8%) responded in the affirmative, stating that the survey accurately captures prototypical CBT and psychodynamic techniques respectively (pilot testers' open-ended responses are provided in table 4.2, in appendix D). The remaining respondents (n=2) were identified as neutral. No pilot tester expressed the view that the survey does *not* accurately capture the techniques evaluated. Consequently, the survey was deemed to have both high instrumental validity, and high content validity—as discussed in the following section.

Although all pilot testers deemed the survey length appropriate, a number of suggestions were made regarding certain questions, which were considered vague or redundant. Consequently the questionnaire was shortened through the omission of 10 questions (5 questions on prototypical psychodynamic techniques, and 5 questions on prototypical CBT techniques). Additionally, based on feedback from pilot study participants, the website interface was made simpler and more user-friendly, the wording and structure of a number of the questions was clarified, and definitions were provided for specialist concepts.

4.4.4. Questionnaire: Reliability and Validity

In addition to pilot testing, the research supervisors reviewed the questionnaire throughout its development to ensure its suitability and sufficiency within the research project. *Alpha reliability* (*Cronbach alpha*) was calculated for two question sub-sets within the questionnaire: a 20-question summative scale, measuring the use of psychodynamic techniques, and a 20-question summative scale measuring the use

[20] As this study is the first of its kind, and by virtue of the research focus (as it examines practitioners' methodologies, rather than research subjects' attitudes or behaviours) other types of validity—such as concurrent validity (correlation with other tests taken at the same time), convergent validity (correlation with other tests that measure the same construct), and divergent validity (differentiation from tests that measure different or unrelated constructs) were outside the scope of this study (Langdridge & Hagger-Johnson, 2009, pp. 105-107).

of cognitive behavioural therapy techniques (see section 9.1.1. below for a further discussion of these measures). Cronbach alpha for the psychodynamic treatment scale was 0.889. Cronbach alpha for the cognitive behavioural therapy treatment scale was 0.889.

It is important to note that this research is based on the hypothesis that psychotherapists may use psychodynamic techniques without identifying them as such, and that some practitioners may hold negative views towards psychodynamic and psychoanalytic modalities while still using psychodynamic techniques—perhaps without being aware of the psychodynamic basis of these techniques—in their clinical work. Consequently, face validity—the apparent validity of an instrument, as perceived by the research subject—was intentionally limited. As Langdridge and Hagger-Johnson write, "face validity is not necessarily desirable" since "items which are face valid mean that participants know what you are trying to measure" and may thereby be influenced to produce biased responses (2009: 104). To appropriately limit face validity, the questionnaire did not explicitly identify the treatment models under examination (CBT and psychodynamic), nor did it identify the study's specific research questions. Information provided to survey participants indicated that the survey was designed to inquire about psychotherapeutic practice and methodology. The specific paradigms under examination were concealed, to the greatest extent possible, by the use of "neutral" language (i.e. avoiding modality-specific language wherever possible), and by randomizing the order of the treatment paradigm questions.

Additionally, questionnaire data were analyzed comparatively, alongside verbal interview data. In analyzing these data sets, key points of convergence/divergence between questionnaire and interview data were assessed, and it is noted that the quantitative representation of clinical practice in the questionnaire showed a high level of agreement with the qualitative representation in the research interviews. In sum, it is held that the questionnaire can be considered a valid and reliable means to gauge respondents' use of a number of psychodynamic and cognitive behavioural therapy techniques in the treatment of male sexual problems.

4.4.5. Questionnaire: Sampling Methodology

The questionnaire was administered from January, 2011 to March, 2013, through the internet. The study population for the questionnaire includes mental health clinicians who treat sexual dysfunction, either as psychotherapy generalists or

as sex therapy specialists. Within this sampling frame, a number of professional designations are relevant (including psychologists, psychiatrists, social workers, etc.). The sampling frame, chosen in consultation with the research supervisors for this project, consists of general psychotherapists affiliated with a number of professional organizations, and self-identified sex therapy specialists affiliated with a number of specialist organizations. Professional organizations were selected based on mandate (either specialist in sex therapy/sexology, or generalist in psychotherapy) and licensure (a membership comprised primarily of licensed mental health professionals). In total, nine professional organizations were selected, four organizations comprising the psychotherapy generalist (PG) sample, and five comprising the sex therapy specialist (ST) sample. The psychotherapy generalist sample was drawn from:

- British Association for Counselling and Psychotherapy (BACP)
- United Kingdom Council for Psychotherapy (UKCP)
- British Psychoanalytic Council (BPC)
- British Psychological Society (BPS)

The sex therapy specialist sample was drawn from:

- Society for the Scientific Study of Sexuality (SSSS)
- Society for Sex Therapy and Research (SSTAR)
- American Association of Sexuality Educators, Counselors and Therapists (AASECT)
- College of Sexual and Relationship Therapists (COSRT) (formerly the British Association for Sex and Relationship Therapy—BASRT)
- Relate—sexual and relationship therapy organization (RELATE)

212 survey responses were submitted. 43 (20.28%) were removed, due to incomplete information, leaving 159 valid responses[21]. Table 4.3 shows the number of respondents from each professional organization.

[21] Due to the sampling/recruitment methodology, the exact response rate cannot be calculated, a limitation discussed in section 4.4.6, below, and in chapter 10.

Table 4.3
Distribution of Questionnaire Respondents' Organizational Membership

	Total Frequency	Percent (%)
Sex Therapy Specialists		
SSSS	10	6.3
AASECT	5	3.1
SSTAR	11	6.9
RELATE	7	4.4
COSRT	55	34.6
Psychotherapy Generalists		
UKCP	40	25.2
BACP	15	9.4
BPS	10	6.3
BPC	6	3.8
Total	*159*	*100.0*

The 159 questionnaire respondents were divided into two distinct practitioner types: sex therapy specialists and psychotherapy generalists.[22] Table 4.4 outlines the practitioner type of questionnaire respondents; overall, 55.3% (n=88) of questionnaire respondents were classified as sex therapy specialists (ST), while the remaining 44.7% (n=71) participants were classified as psychotherapy generalists (PG). It is important to note, however, that membership in these organizations is non-exclusive, and some members of psychotherapy generalist organizations may also be members of sex therapy specialty organizations.

Table 4.4
Questionnaire Respondents' Practitioner Type

	Total Frequency	Percent (%)
Sex Therapy Specialist (ST)	88	55.3
Psychotherapy Generalist (PG)	71	44.7
Total	*159*	*100.0*

[22] Because the number of respondents registered with the British Psychoanalytic Council (BPC) was so low (n=6), they were included in the psychotherapy generalist group. The data for the psychotherapy generalist group was analyzed both with the BPC sub-group included, and without them; results for the psychotherapy generalist group's adherence to psychodynamic and CBT techniques were not found to differ to a statistically significant degree when the BPC sub-group was omitted.

Questionnaire participants were recruited through a number of online avenues, using a standardized recruitment email (provided in appendix E). SSSS, AASECT, and SSTAR members were contacted through the online listservs for these organizations, with two successive recruitment emails sent to each listserv. For RELATE, a recruitment email was sent out to staff and affiliates, by the organization's administration. For all other organizations—including COSRT, UKCP, BACP, BPC and BPS—email contacts were obtained through each organization's public registry, and members were emailed directly on two successive occasions.

The questionnaire targeted practicing psychotherapists, and sex therapists with a variety of professional designations. Table 4.5 indicates the professional designation/licensure of all questionnaire respondents.

Table 4.5
Distribution of Questionnaire Respondents' Professional Licensure

	Total Frequency	Percent (%)
Psychotherapist	85	53.5
Clinical Psychologist	16	10.1
Counselling Psychologist	9	5.7
Licensed Counsellor	10	6.3
Social Services Worker	6	3.8
Nurse	2	1.3
Other Mental Health Care (Not Specified)	24	15.1
Psychiatrist	1	0.6
Sex Coach	1	0.6
Medical Doctor (Sexual Specialist)	2	1.3
Medical Doctor (Obstetrician/Gynecologist)	1	0.6
Medical Doctor (General Pracititoner)	1	0.6
Sexologist	1	0.6
Total	*159*	*100.0*

Questionnaires were also used as a recruitment tool for the verbal interviews. On the questionnaire form respondents were invited to participate in an open-ended interview at a later time. In the online form, a dedicated section allowed respondents to enter their contact info.[23] Otherwise, data were recorded anonymously.

4.4.6. Questionnaire Response Rate

The exact response rate of the survey cannot be calculated, due to the use of email recruitment, and listservs. The number of members contacted through listservs

[23] While this recruitment strategy meant that respondents who chose to participate in a later interview were not completely anonymous in their questionnaire responses, the survey nonetheless made provision for their confidentiality, as discussed in the "ethics" section below.

is unknown, and the number of valid/invalid email addresses is unknown. It is also unknown how many prospective participants actually received the email, as a number may have overlooked the email, or deleted it without reading. Additionally, the number of clinical practitioners on these listservs is not known (as membership of the sex research/therapy organizations is comprised of sex researchers, sex educators, and allied professionals, alongside clinicians). The fact that some clinicians are members of more than one professional group (and may have received the invitation through more than one listserv/email) further complicates response-rate estimates. Furthermore, the number of psychotherapy generalists who work in the treatment of male sexual dysfunction—and for whom the study would be applicable—is unknown.

Estimated response rate is low, likely from 5%-10% of eligible participants, varying by organization (with a higher response rate likely for sex therapy specific organizations). It is necessary to note the implications that this unknown—and likely low—response rate have for the study. There is a risk of response bias in both the specialist and generalist population groups. In particular, psychotherapy generalists who are especially concerned with sexual health issues may be overrepresented amongst the respondents. Additionally, more research-oriented sex therapy practitioners (who may be more actively involved with, and attentive to, sexual science organizations listservs) may be overrepresented. As recruitment was administered online, through emails and listservs, for both groups, the sampling methodology may have also favoured more technologically savvy respondents. The limitations of the sampling methodology, and the challenges of an unknown, and prospectively low, response rate—and implications for future study—are addressed at greater length in chapter 10.

4.5.1. Verbal Interviews

The verbal interviews gathered qualitative data that expands upon the, primarily quantitative, data obtained by the questionnaire, and aimed to more broadly capture the insights of practitioners working in the field. As stated above, the questionnaire was designed principally to answer the first research question, and to determine which techniques are used most commonly in the treatment of men's sexual dysfunctions. By contrast, the verbal interviews were designed to answer the second, research question by supplying data for a more intensive analysis of how therapists understand men's sexual dysfunctions, how therapeutic techniques are

administered in the clinical setting, and how clinicians can best integrate psychodynamic methods in their work. In simple terms, the interviews were designed to discover *what* works and what does not work in the psychotherapeutic treatment of men's sexual dysfunction, and how psychodynamic techniques can best be integrated within this treatment process.

In order to clarify the place of psychodynamic methods in sex therapy, this research project aimed to gain a broad methodological overview of the sex therapy discipline, identifying the prevalent techniques used in sex therapy, and determining: which clinical techniques distinguish sex therapy as a specialty, and which methodologies are specific to sex therapy, as opposed to other psychotherapeutic fields? Through thematic analysis of the qualitative data (see the data analysis section below for a more comprehensive discussion of analytic techniques), a number of key areas were identified, including: biopsychosocial and integrative treatment practice, diagnostic and assessment practice, goal-setting and case formulation, working critically with diverse populations, aetiological theories of sexual dysfunction/problems, and the place of psychodynamic techniques in clinical practice (these thematic areas align with the secondary aims of this research, and with the overview of chapters, described in chapter 1, and in section 4.2., above). As stated above, the core objectives of this research method were: to understand how clinicians use a variety of techniques, particularly psychodynamic methods, in the treatment of sexual dysfunction, and to gain insight into the treatment field, in order to help establish how psychodynamic and psychodynamically-informed theories and techniques can best be integrated into sex therapy.

4.5.2. Verbal Interviews: Survey Construction

In consultation with the supervisors for this research project, a set of questions was devised, to serve as a guideline for the open-ended verbal interviews. Data from the questionnaire, and from ongoing interviews, served as a point of reference for this component of the research. As data were gathered and analyzed throughout the research process, the flexible 'script' for the verbal interviews changed to accommodate new knowledge and pursue emergent lines of questioning.

While set questions served as topical guidelines for the open-ended interviews, interviewees were encouraged to discuss the areas that they deemed most pertinent. Consequently, a semi-structured interview technique was used in which themes of interest that arose in the dynamic 'back-and-forth' of the interview were explored.

As Smith and Osborn write, in a semi-structured interview, "the respondent shares more closely in the direction an interview takes, and the respondent can introduce an issue the investigator had not thought of. In this relationship, the respondents can be perceived as the experiential expert [sic.] on the subject and should therefore be allowed maximum opportunity to tell their own story" (2003, p. 57).

In developing and maintaining the interview 'script' the research supervisors were consulted ongoingly, to ensure sufficient detail and topical relevance, and feedback was solicited from interviewees regarding key topics of interest and inquiry for future research interviews.

4.5.3. Verbal Interviews: Pilot Testing

The semi-structured verbal interview guide was subjected to a four-phase review process, involving: 1) peer review, 2) supervisory review (two stages), and 3) subject expert review. First a prototype interview template was developed. This prototype was assessed by a peer review committee of 3 psychology graduate students, who evaluated its completeness and accuracy in assessing the content addressed by the primary and secondary aims of this research project. The interview guide was revised in accordance with their feedback before being reviewed by the research supervisors for this project. Research supervisors' feedback was then incorporated, and the revised interview guide was submitted to review by two subject experts, who were asked to assess it for its accuracy in capturing data about foundational sex therapy techniques, and the role of psychodynamic practice in sex therapy work, with particular attention to any possible omissions. Feedback was provided by the subject expert reviewers, and incorporated into a third revision of the guide. Finally, a research interview—using the guide—was conducted with the primary research supervisor for this project, who then offered feedback on both the application of the interview guide, and the interview style used, contributing to a fourth and final revision of the interview guide.

4.5.4. Verbal Interviews: Quality of the Evidence

Several methods were used to ensure high-quality evidence. McGrath and Johnson suggest that we may consider the quality of research evidence according to Lincoln and Guba's concept of "trustworthiness," which "encompasses four main ideas—the truth value or credibility, the applicability, the consistency, and the neutrality of the information" (Lincoln and Guba, 1985, cited in McGrath & Johnson,

2003, p. 43) . These concepts, they suggest, align roughly with "the more familiar concepts of internal validity, external validity, reliability, and objectivity" (Ibid. p. 43).

To verify the "trustworthiness" of the survey findings, interview data were cross-referenced against several other data sources. First, the interview findings were cross-referenced against the questionnaire data set, with particular focus on data drawn from questionnaires administered to sex-therapists, to ensure consistency. As the questionnaire and verbal interviews were administered to similar representative samples of sex therapists, relative agreement between their findings is deemed indicative of broad applicability/external validity, and consistency/reliability. Second, the findings of the interview were analyzed in relation to the scholarly literature on the topic. Theoretically, the interview data should expand on the clinical literature; any significant contradiction between interview data and the accepted sex therapy literature were considered grounds for further investigation, whereas general agreement between these two sources of data suggests the credibility/internal validity of the interview data. It was also noted, however, that complete agreement with the clinical literature may indicate that interviewees were attempting to demonstrate that their work accords with accepted therapy practices, as such, incongruence between interview content and the wider literature was a point of critical examination. Third, interview data were ongoingly assessed in relation to previous interviews, especially for methodological purposes; as with the sex therapy literature, significant disagreement between interviews was considered a basis for further investigation. Finally, regular consultation with the research supervisors confirmed data quality, through supervisory assessment of the data collection and data analysis methods used, and critical feedback on the research techniques used.

4.5.5. Verbal Interviews: Sampling Methodology

The interview survey targeted practicing psychotherapists and subject-area experts working in the treatment of sexual dysfunction from a host of professional designations. A total of 34 (n=34) individuals were interviewed. For interview recruitment, a convenience sampling method was used, employing a number of participant recruitment techniques: the questionnaire was used (as stated in section 4.4.5, above) to identity potential interviewees. Additionally, conferences and professional networking events were used to make contact with potential research participants; as with the questionnaire, this method comprised, in part, a "sampling of

natural groups" (Langdridge & Hagger-Johnson, 2009). A snowball sampling approach was also used, focusing on potential participants recommended by previous interviewees. "With this sampling technique," Langdridge and Hagger-Johnson explain, "the researcher will make contact with a small number of potential participants whom they wish to recruit to the study. They will then use these initial contacts to recruit further participants" (2009: 57). As Langdridge and Hagger-Johnson acknowledge (Ibid., 57-58), the snowball sampling technique introduces a risk of bias, as it increases the likelihood that the sample will be drawn from clinically 'like-minded' individuals; as such, use of the snowball sampling method was secondary to the use of the questionnaire, and professional networking events as recruitment avenues.

Interviews were carried out between March 2012 and October 2013, in-person, over the telephone, and via the internet (using Skype).

4.5.6. Qualitative Data Analysis and Reporting

Three data analysis methods were used conjunctively in analyzing the qualitative interview data: grounded theory, thematic analysis, and content analysis. Grounded-theory-based analysis entailed an ongoing process of critical and analytic reflection carried out throughout the course of the research project. Methodologically, in conducting and analyzing interviews, an analytically inductive approach was used, which, Katz writes, can be "described more appropriately...as 'retroduction' than as induction: a 'double fitting' or alternating shaping of both observation and explanation, rather than an ex post facto discovery of explanatory ideas" (2001, pp. 333-334). This method entailed working 'back and forth' between the data obtained through questionnaires and interviews and the underlying research theories and interview praxis (Glaser & Strauss, 1967). This kind of grounded theorizing—which allows for a dynamic relationship between the "collection and analysis of data"—allowed the flexibility necessary to take full advantage of the interview format (Charmaz, 2003: 251). Reflective notes, written for each interview, were used as a reflective practice technique to assess: the efficacy of the research method, the implications of interview content, and in particular, the contributions made by both the interviewee and the interviewer.

Thematic analysis was used to analyze the interview data, and identify themes/patterns expressed by interviewees. As Boyatzis writes,

> a theme is a pattern found in the information that at minimum describes and

> organizes the possible observations and at maximum interprets aspects of the phenomenon. A theme may be identified at the manifest level (directly observable in the information) or at the latent level (underlying the phenomenon) (Boyatzis, 1998, p. 4).

Thematic analysis of the interview data was used to identify themes at both the manifest/explicit level, and at the latent/implicit level. In the thematic/content analysis tables for each chapter (provided in the appendices), explicit and implicit themes are identified and differentiated. It is also asserted that the themes produced through thematic analysis can be either inductive (deriving directly from analysis of the data), or deductive (deriving from a prior theory or research)(Braun & Clarke, 2006). Rather than an either-or methodology, however, Boyatzis has asserted that this model can be considered on a continuum between theory-driven and data-driven approaches. An inductive, data-driven coding model has been used in this research, with the primary coder deriving the themes and codes from a close reading of the data, and through inter-rater consultation.

After initial themes and codes were developed, the coding system was revised, and reliability was confirmed through an assessment of inter-rater reliability. In thematic analysis, inter-rater reliability is considered to be: the consistency of judgment between multiple different raters. A graduate student in psychology was recruited to assess inter-rater reliability through double coding; both reviewers analyzed the same 20-page section of interview transcripts, to identify possible codes. In this method,

> each person makes judgments without interacting or seeing the judgments of the other observer. Following the observation period or completion of the judgments, the two observers compare their results…the two observers [then] discuss each observation until agreement is reached (Boyatzis, 1998, p. 151).

Through this method, a set of thematic codes was agreed between reviewers. A second, 20-page section of text was then assigned to each reviewer to code, using the pre-agreed set of codes (these codes are listed in the inter-rater research interview coding scheme/chart, provided in appendix F). Inter-rater reliability was calculated for agreement on the presence of each code, between each reviewer. Cohen's Kappa for inter-rater reliability was .72, which is regarded as good (Ballinger, Yardley, & Payne, 2004). Finally, the primary researcher developed a complete list of codes/themes, based on the content of all interviews (the complete qualitative interview coding scheme/chart is provided in appendix G). A peer reviewer—a PhD

student in psychology—was asked to review the interview coding scheme/chart, and provided with summary/example statements of the themes outlined in the coding scheme. The reviewer provided qualitative feedback on the accuracy and completeness of the complete coding chart; in this assessment, the reviewer deemed the complete chart to be consistent with the previously developed inter-rater chart, and accurate in reflecting the themes/sub-themes in the interviews.

Content analysis was also used, to assess the number and percentage of interviewees who mentioned each theme. Content analysis, Joffe and Yardley write, is a "partially quantitative method", which "involves establishing categories and then…[determining] the frequency of [their] occurrence" (2004, p. 56). Thematic/content analysis tables for this research are provided and referenced throughout the following chapters, and indicate: the relevant themes/sub-themes identified in the research interviews, the total number and percentage of interviewees who mentioned each theme/sub-theme, the number and percentage who mentioned each theme/sub-theme explicitly and implicitly, and representative statements for each theme/sub-theme. A sample of a coded interview transcript is provided (in appendix H).

4.6. Controls for Researcher Bias

First and foremost, researcher bias was controlled by pilot test of the questionnaire (especially to avoid prejudicial or leading content, wording, or structure), and supervisory review of the semi-structured interview guidelines. Second, several steps were taken in order to minimize the risk of an experimenter bias effect, through the application of reflexive practice. As Maracek writes, reflexive practice is a method in which "qualitative researchers engage in a deliberate process of reflection about how their social location (for example, social class, gender, age, status, ethnicity), value commitments, and personal history have influenced the course and outcome of a research project" (2003, pp. 62-63). The researcher's psychotherapeutic and academic biases, which were deemed to present the most significant challenge to researcher objectivity, were a primary area for reflexive practice. Reflexive practice was engaged through the use of a reflective journal throughout the research project, through regular consultation with research supervisors, and through the organization and maintenance of a psychodynamic research seminar with peers (as this research seminar was focused on psychoanalytic and psychodynamic research, it was especially useful in ensuring that the

engagement with psychodynamic concepts was rigorous and accurate in this research project).

4.7.1. Research Ethics: Assessment of Risk

This research project is fully compliant with UCL's ethics guidelines for research with human subjects, and falls within the range of minimal risk. A study is considered to involve minimal risk "when the procedures or activities in the study are similar to those experienced by participants in their everyday life" (Shaughnessy, Zechmeister, & Zechmeister, 2006, p. 66). As study participants were practitioners and researchers (rather than clients/patients), and as the survey inquires about professional practice (rather than more personal issues), the study was deemed to involve minimal risk.

Research ethics board (REB) approval was not required for this research project. As per UCL's ethical guidelines (outlined in UCL's Research Ethics Committee guidelines, available at www.grad.ucl.ac.uk/ethics/forms/guidelines.pdf), this research is exempt (according to p. 2, section c) as it involves survey and interview research, and could not "reasonably place the participants at greater risk of criminal or civil liability or be damaging to the participants' financial standing, employability, or reputation". Exemption from REB review, and ethical approval for the research to proceed, was granted by the head of the Department of Clinical, Educational and Health Psychology on 20/03/11.

4.7.2. Research Ethics: Informed Consent, Anonymity and Confidentiality of Research Participants

Informed consent was obtained from all research participants. The informed consent declaration, for both the questionnaire and verbal interviews, specified the nature of the study, its purpose and intended audience, and indicated that participation was strictly voluntary and that the interviewee could discontinue the interview at any point without penalty.

The anonymity and confidentiality of online questionnaire respondents were maintained by the use of a secure online server. Any identifying information on questionnaire respondents (i.e. contact information for those who chose to participate in a verbal interview) was stored on a password-protected server, and a password-protected computer.

All interviews were audio-recorded and transcribed. Recordings and

transcriptions were stored in digital format on a password-protected computer. Additionally, paper copies of transcriptions were kept, as back-ups, in a locked drawer in the researcher's workspace.

Unlike the surveys, interviews were not administered—and are generally not reported—anonymously. Informed consent for interviews specified that the interview participant would be cited, by name, as an academic source in this dissertation, and any published results. In a number of cases, interviewees asked to maintain anonymity for, or redact, certain portions of their interviews. In all cases these requests have been honoured. Additionally, in instances where an interviewee's comments might prove unduly controversial or professionally compromising, their comments have been reported anonymously.

4.7.3. Research Ethics: Steps Taken to Ensure Anonymity/Confidentiality of Patients/Clients

In addition to the safety, anonymity and confidentiality of research participants, a number of steps were taken to safeguard the anonymity and confidentiality of patients/clients. As this research project examined the practices of mental health professionals, case studies and clinical examples were common in the interviews (although, as indicated above, the study did not involve direct contact with clients or patients).

First, the research was subject to, and adhered to all UCL ethics protocols, and obtained ethical approval (as outlined in section 4.7.1). Additionally, interview participants were asked to report on case material (where relevant) anonymously, within the bounds of confidentiality. No content that could serve to identity specific clients was requested, and any such content was carefully screened and removed through a number of steps. First, interviews were carefully examined by the researcher for instances where interview content (especially case material reported by interviewees) might place client confidentiality at risk. All such instances were redacted from the collected data. Additionally, each interviewee was asked to review the transcription of their interview, to monitor for content that might put client confidentiality at risk—all relevant sections were redacted as advised by the interviewees. Finally, the data reported in this thesis has been closely reviewed for any remaining instances where client confidentiality may be compromised; all such instances have been removed.

CHAPTER 5. PRACTITIONERS' USE OF THE BIOPSYCHOSOCIAL MODEL AND INTEGRATIVE FRAMEWORK

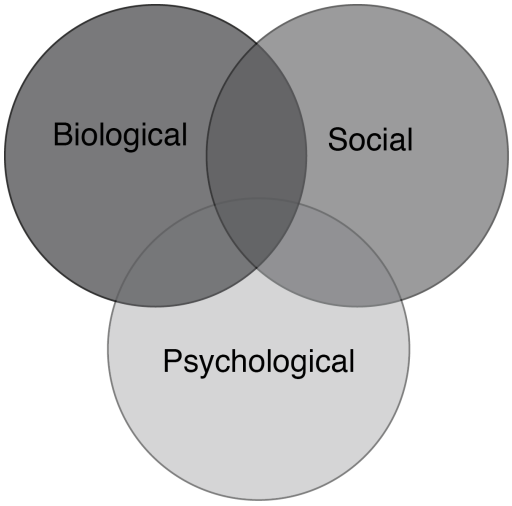
5.1. Introduction: Practitioners' use of the Biopsychosocial Model and Integrative Practice

As illustrated in previous chapters (see especially chapter 3), the biopsychosocial model is an area of significant emphasis in contemporary sex therapy research. However, a number of researchers have stated that this emphasis is often more theoretical than applied, and frequently does not translate into the use of integrative and biopsychosocial best practices (the "lip service" alluded to in chapter 3) (Berry & Berry, 2013a, 2014; McCarthy & McDonald, 2009a, p. 31). The rationale of Chapter 5 is to present the data from this study on the role of the biopsychosocial model, and the implementation of an integrative treatment approach, in clinical practice. The aim here is to explore how clinicians conceive of and implement biopsychosocial practice, and the chapter begins by presenting data on respondents' self-reported use of the biopsychosocial model. A discussion follows, regarding the conceptualization of integrative approaches within the sex therapy field, including the integration of different psychotherapy modalities and the integration of psychotherapy with other (especially biomedical) health interventions. Another significant area of psychosocial integration—the role of the client's partner within the integrative approach to sex therapy—is addressed and highlighted. Using the qualitative and quantitative data from this study, a key question is explored: in the sex therapy field, does it take two to tango?

5.2. Respondents' Use of the Biopsychosocial Model and Integrative Treatment

The biopsychosocial model of sexual health is the underlying framework for accepted process of care standards in sexual healthcare, as enshrined in World Health Organization (WHO) guidelines (Berry & Berry, 2013a; Hatzimouratidis et al., 2010; Montorsi, Adaikan, et al., 2010; Montorsi, Basson, et al., 2010). As discussed in chapter 3, clinicians working within the biopsychosocial model view the biological, psychological, and social aspects of the patient's sexual experience, and sexual health, as inextricably correlated. This framework is illustrated in figure 5.1.

Figure 5.1: The Biopsychosocial Model of Human Sexuality (adapted from Berry & Berry, 2013a)



In effect this model prescribes attention to—and, as required, treatment of—the biological, psychological, and social factors affecting the client's sexuality and sexual problems. In this chapter, data on practitioners' adherence to the biopsychosocial model are presented, and the integrative treatment orientation suggested by the evidence gathered in this study is described.

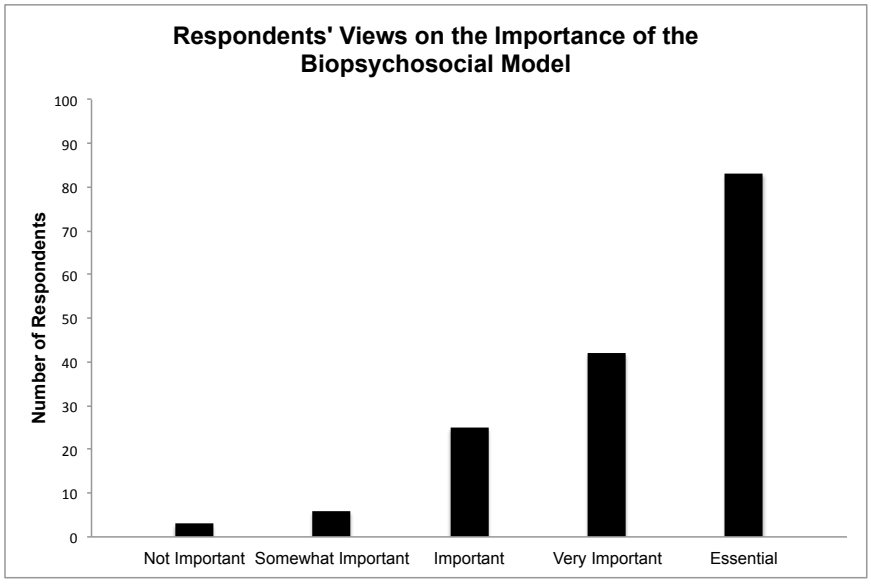
5.2.1. Clinicians' use of Biopsychosocial and Integrative Practice: Quantitative Survey Results

As stated above, this research project focuses on the psychosocial factors in male sexual problems, and the psychotherapeutic treatment thereof. Consequently, a comprehensive discussion of the biological facets of male sexual dysfunction is beyond the scope of this dissertation (though the reader is referred to chapter 3, sections 3.2.4 and 3.4.2, for a brief overview of key biological aspects of male sexual dysfunction and treatment). It must again be stressed, however, that this research is conceived within the biopsychosocial model, which appears to prevail amongst a strong majority of psychotherapists and sex therapists surveyed. Table 5.1 and Figure 5.2 show questionnaire respondents' self-reported view of the importance of the biopsychosocial model, on a five point Likert scale, ranging from "not important" to "essential", in response to the question: "Which of the following best describes your view on the biopsychosocial treatment model?".

Table 5.1
Views on the importance and use of the biopsychosocial (BPS) treatment model showing frequency of endorsement and related percentage for all questionnaire respondents, sex therapy specialists (ST) and psychotherapy generalists (PG)

	Frequency (All)	Percent (%)	Frequency (ST)	Percent (%)	Frequency (PG)	Percent (%)
Views on the importance of the BPS model						
Not Important	3	1.9	1.0	1.1	2	2.8
Somewhat Important	6	3.8	1.0	1.1	5	7.0
Important	25	15.7	8.0	9.1	17	23.9
Very Important	42	26.4	25.0	28.4	17	23.9
Essential	83	52.2	53.0	60.2	30	42.3
Total	*159*	*100*	*88*	*100*	*71*	*100*
Use of the BPS model on average						
Not Important	8	5.0	2	2.3	6	8.5
Somewhat Important	7	4.4	1	1.1	6	8.5
Important	17	10.7	6	6.8	11	15.5
Very Important	64	40.3	33	37.5	31	43.7
Essential	63	39.6	46	52.3	17	23.9
Total	*159*	*100*	*88*	*100*	*71*	*100*
Use of BPS model with most recent client						
Not Important	11	6.9	3	3.4	8	11.3
Somewhat Important	10	6.3	3	3.4	7	9.9
Important	21	13.2	10	11.4	11	15.5
Very Important	71	44.7	37	42.0	34	47.9
Essential	46	28.9	35	39.8	11	15.5
Total	*159*	*100*	*88*	*100*	*71*	*100*

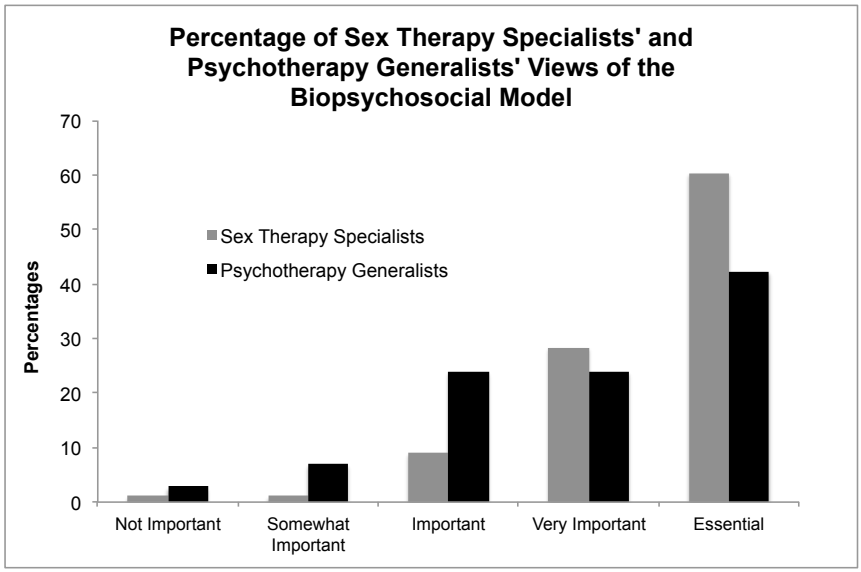
Figure 5.2: Respondents' Views on the Importance of the Biopsychosocial Model



When asked, "which of the following statements best describes your view on the biopsychosocial treatment model?" a strong majority (78.6%) of respondents classified the biopsychosocial model as "very important" or "essential," with a majority of respondents (52.2%) classifying the biopsychosocial model as "essential". Thus, a pronounced emphasis on the importance of the biopsychosocial model in the treatment of sexual dysfunction is evident amongst the entire sampling frame.

Figure 5.3 shows sex therapy specialists', and psychotherapy generalists' respective self-reported views of the biopsychosocial model, on a five point Likert scale, ranging from "not important" to "essential", in response to the question: "Which of the following best describes your view on the biopsychosocial treatment model?". An independent sample t-test was performed, which revealed that sex therapy specialists ($M = 4.45$) were, on average, significantly more likely to place a higher priority on the BPS model relative to psychotherapy generalists ($M = 3.96$), $t(157) = 3.290$, $p = .001$.

Figure 5.3: Percentage of Sex Therapy Specialists' and Psychotherapy Generalists' Views of the Biopsychosocial Model

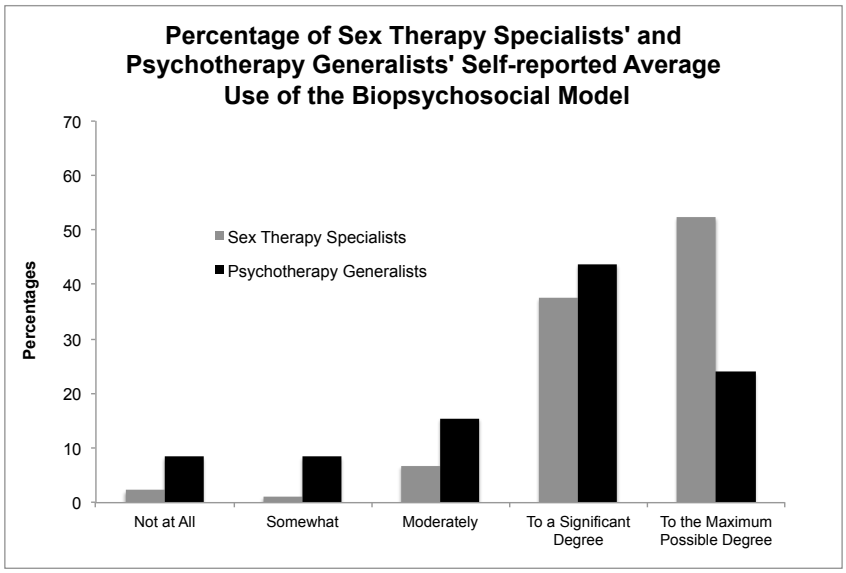


This finding suggests that, while both groups consider the biopsychosocial model to be highly important in the treatment of male sexual dysfunction, it is considered more important/essential by sex therapists. It is important to note that this finding (as reported in Figures 5.2 and 5.3) reflects respondents' overall *view* of the importance of the biopsychosocial model within the treatment field in general (but does not indicate their *use* of the BPS model).

By contrast, figures 5.4 and 5.5, below, show sex therapy specialists', and psychotherapy generalists' self-reported *average use* of the biopsychosocial model in their clinical practice. Figure 5.4 shows these respective participant groups' scores, measured on a five point Likert scale, ranging from "not at all" to "to the maximum possible degree", in response to the question: "On average, in the treatment of men's sexual dysfunctions, to what extent do you use the biopsychosocial treatment model (i.e. taking all three facets into account in diagnosis, and treating all three facets, or

referring for treatment of all three facets as needed)?". An independent sample t-test was performed which revealed that sex therapy specialists ($M = 4.36$) were, on average, significantly more likely to report using the biopsychosocial model to a high degree, *on average* in their work with male clients, than psychotherapy generalists ($M = 3.66$), $t(157) = 4.354$, $p < .001$.

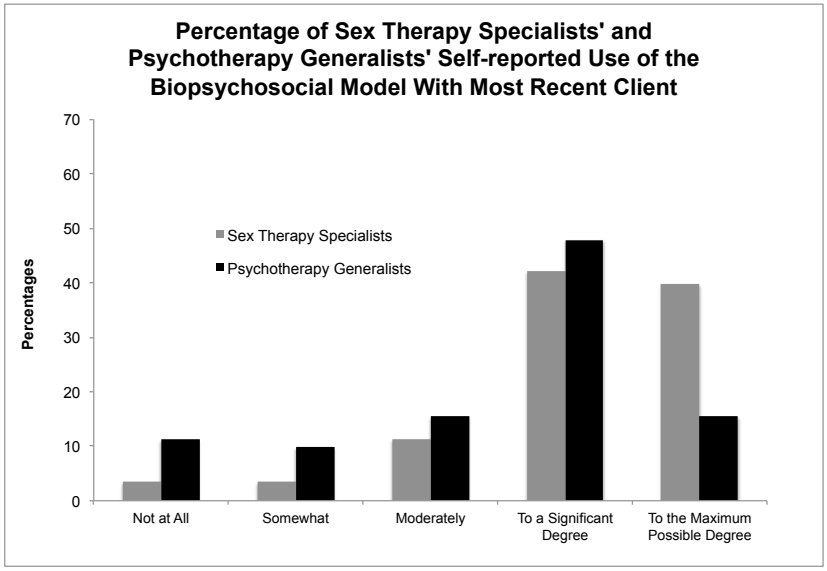
Figure 5.4: Percentage of Sex Therapy Specialists' and Psychotherapy Generalists' Self-reported Average Use of the Biopsychosocial Model



Overall, a substantial proportion of research participants report using the biopsychosocial treatment model, on average, in their clinical practice, with sexual therapy specialists showing a slightly higher self-reported use of biopsychosocial practice.

Figure 5.5 shows sex therapy specialists', and psychotherapy generalists' self-reported use of the biopsychosocial model with their *most recent* relevant client, on a five point Likert scale, ranging from "not important" to "essential", in response to the question: "With the most recent patient that you treated for male sexual dysfunction, to what extent did you use the biopsychosocial treatment model?". An independent sample t-test was performed, which revealed that sex therapy specialists ($M = 4.11$) were, on average, significantly more likely to use the biopsychosocial model in the treatment of their *most recent* male client than psychotherapy generalists ($M = 3.46$), $t(157) = 3.752$, $p < .001$.

Figure 5.5: Percentage of Sex Therapy Specialists' and Psychotherapy Generalists' Self-reported Use of the Biopsychosocial Model With Most Recent Client



As with respondents' self reported *average* use of the biopsychosocial model, a substantial proportion of research participants report using the biopsychosocial treatment model *with their most recent* male client in their clinical practice to a significant degree, with sexual therapy specialists showing a higher self-reported use of biopsychosocial practice with their most recent relevant client.

5.2.2. Clinicians' use of Biopsychosocial and Integrative Practice: Qualitative Interview Results

Data from research interviews, on the key themes in the biopsychosocial domain, are presented in table 5.2 and table 5.3 (appendices I and J). Emphasis on the clinical use of a biopsychosocial orientation was a prominent theme in a majority (55.9%) of research interviews. Sub-themes in this area included: emphasis on a holistic view of the client, and the importance of considering embodiment and physical factors, alongside psychological and relational factors, in the client's sexual experience/repertoire. Additionally, a considerable number of participants (44.1%) emphasized the use of an integrative biopsychosocial approach to treatment. While interviewees stressed the possible role of sexual dysfunction as an early marker of illness—and the importance of early medical screening—the limitations of a strictly medical or pharmacological approach were also emphasized. Overall, interview data place high emphasis on psychological and social factors in the treatment of male sexual problems, a finding that might be expected from the professional group

surveyed (which is comprised primarily of mental health professionals).

Consistent with published clinical research, many clinicians surveyed appear to conceive of biopsychosocial practice within a model that evaluates both immediate interpersonal factors—such as relationship dynamics with a sexual partner or partners—and cultural and sociological factors—including early history, family of origin, and the influence of other socialization elements. This model finds clear iteration in Levine's "first principle of clinical sexuality," which states that, "all sexual behavior, solitary or partnered, normal or dysfunctional, is influenced by biological, psychological, interpersonal and cultural factors of normality and morality" (Levine, 2007a, p. 450; 2007b). It is important to highlight that Levine explicitly includes both "normal" and "dysfunctional" sexual behaviour, rather than focusing solely on pathology and sexual problems (Levine, research interview, 08/01/2013).

Additionally, this interpretation of the biopsychosocial model extends beyond the sexual aspects of the client's life, situating them within a broader personal and relational context. As one interviewee states, a biopsychosocial orientation to sexual therapy may take the position that

> all behaviour, including sexual behaviour, is the result of a dynamic interaction process between biological factors, psychological factors, and socio-cultural factors, keeping in mind that each of those broad categories has multiple levels...This is a kind of mutual thing where each of those factors is interacting at the same time with each other. So, I like to start there because when you start to think about causation, then you've got to understand that you might pick out a social factor, or a psychological factor, but at the same time it's always interacting with other things (Cass, research interview, 03/02/2013, transcript p. 14, lines 37-44).

Published data suggest that this model enables psychosexual therapists to attend to both constructive and inhibiting aspects of the client's sexuality in the biological, psychological, and social spheres (Bancroft, 1999; Bancroft, Graham, Janssen, & Sanders, 2009; Jansen, Vorst, Finn, & Bancroft, 2002; Perelman, 2005c). As McCarthy states, "I think one of the best ways of thinking about it is: physiologically, what promotes healthy sexuality, what subverts it? Psychologically, what promotes it, what subverts it? And relationally, what promotes it, what subverts it?" (research interview, 17/01/2013, transcript p. 3, lines 28-31). Qualitative interview data indicate that this approach requires that the clinician

maintain a high level of holism in interpreting the client's sexual difficulties and situating them within a wider context that considers a wide range of health factors.

5.2.3. Discussion of Results: Use of the Biopsychosocial model

Quantitative survey findings appear to support the hypothesis that the biopsychosocial model is considered highly important by both psychotherapy generalists and sex therapy specialists. According to one interview participant with research experience in integrative practice, the high level of emphasis on biopsychosocial practice may reflect a shift in the healthcare field, in which sexual concerns are treated from an increasingly integrative and biopsychosocially-informed vantage point across healthcare specialities. This, he states, may constitute "a general movement from dealing with fairly straightforward presentations of sexual problems to dealing with a wide complexity of inter-related problems, which can be: relationship, psychological, medical, etc." (Daines, research interview, 31/03/2013, transcript p. 3, lines 30-33). This ostensive shift towards a more integrative orientation that addresses a complex interplay of related problems implies an important logistical question: how do sexual healthcare specialists implement a biopsychosocially integrative treatment protocol in practice?

As stated above, overall the data from this study strongly suggest that many psychotherapists—both generalists and sex therapy specialists—hold the view that treatment of men's sexual difficulties may be optimized by attending to social and relational factors (appendices I and J). However, while a considerable majority of questionnaire respondents indicate that the biopsychosocial model is either "very important" or "essential" (table 5.1, and figures 5.2 and 5.3) a lesser number report *using* the biopsychosocial model on average in their practice (figure 5.4) and with their most recent client (figure 5.5). These results accord with wider research on the biopsychosocial model, which suggest that the rhetorical endorsement of biopsychosocial practice is often not matched by biopsychosocial practices, and indicate the need for ongoing work on integrative treatment protocols that can be used across settings (Berry & Berry, 2013a; McCarthy & McDonald, 2009a). As such, data from this study appear to support the hypothesis that, while emphasis on the importance of biopsychosocial practice is high amongst psychosexual therapists, strategies for implementation are less consistent. Consequently, integrative approaches to treatment appear to be a key area of importance within the biopsychosocial model.

5.2.4. Discussion of Results: Integrative approaches to the Biopsychosocial Treatment of Male Sexual Problems

> "Sex doesn't start from vacant terrain. It starts from where the person begins" (Ravella, research interview, 11/01/2013, transcript p. 13, lines 28-29).

The above quote encapsulates the orientation of this project: to examine the role of psychotherapeutic techniques in the treatment of men's sexual difficulties, from a biopsychosocial perspective that considers the patient's sexuality as a multi-dimensional construct, which interacts dynamically with other facets of their life. One of the primary findings of this research is that an integrative psychotherapy model is highly prevalent in contemporary sex therapy, with a significant proportion of survey participants reporting the use of an integrative approach in their clinical practice. In this domain, a core message in the qualitative data is that sexuality and sexual problems must be considered within the wider context of the individual's life and relationships—in Ravella's terms, "where the person begins". From this viewpoint, integration is not limited to modal eclecticism, but also involves a methodical effort to understand clients within the context of their lived experience—where they begin, physically, psychologically, and socially. This biopsychosocial clinical orientation is foundational to the process of care standards of sexual medicine, and is a well-documented clinical mandate in contemporary sexual therapy (Berry & Berry, 2013a; Montorsi, Basson, et al., 2010).

The biopsychosocial model strongly indicates the importance of an integrative treatment orientation, and interdisciplinary treatment practice. Several types of integration within the biopsychosocial treatment of men's sexual health problems can be identified in the data from this study (Berry & Berry, 2014). These integrative modalities include:

1) Integration of medical and psychosocial interventions
2) Integration of psychotherapeutic modalities, and
3) Integration of the couple relationship within the assessment and treatment model.[24]

While the value of multidisciplinary treatment facilities was emphasized in the qualitative data, it appears that the logistics/infrastructure of healthcare delivery

[24] Although, as emphasized above, this research project focuses on psychotherapeutic and psychosocial interventions, and on the integration of the couple relationship within the assessment and treatment model, a brief discussion of treatment protocols for the integration of medical and psychological treatments is warranted, and is included in section 5.4.2 below.

systems overarchingly necessitate the use of referral networks amongst specialist healthcare providers (in lieu of multidisciplinary, 'one-stop' treatment centres), with a number of interviewees (41.2%) stressing the importance of a well-developed referral network. Below, a treatment algorithm (adapted from Berry & Berry 2013a) is provided. This algorithm is designed to help structure the biopsychosocial treatment process, and address the apparent challenges of integration (see figure 5.6).

Within the area of psychotherapy integration specifically, both interview and questionnaire data in this study suggest that a technically integrative psychotherapy approach is highly common amongst psychotherapists and sexual therapy specialists working in the treatment of male sexual dysfunction. This finding, discussed in section 5.4.3, is consistent with extant research on the high prevalence of technical and theoretical integration amongst psychotherapists (Grencavage & Norcross, 1990; Lambert, 1992; Norcross & Goldfried, 2005; Prochaska & Norcross, 2007). In this study, a particularly significant research finding is the apparent divergence between *theoretically explicit* and *theoretically implicit* integration of both psychotherapy techniques and biopsychosocial treatment (discussed further in section 5.2.6, and in chapters 8 and 9), a point which illustrates the potential need for integration protocols—including methods for integrating psychodynamic and cognitive behavioural techniques—in the treatment of male sexual problems.

The integration of couple therapy, and the inclusion of the partner within the treatment process, is a recurrent point of emphasis amongst research participants, as outlined in sections 5.5-5.5.3 below. This form of integration illustrates the utility of the biopsychosocial model more generally, as it indicates the inherently interrelating nature of biological, psychological and relational dimensions of sexual problems.

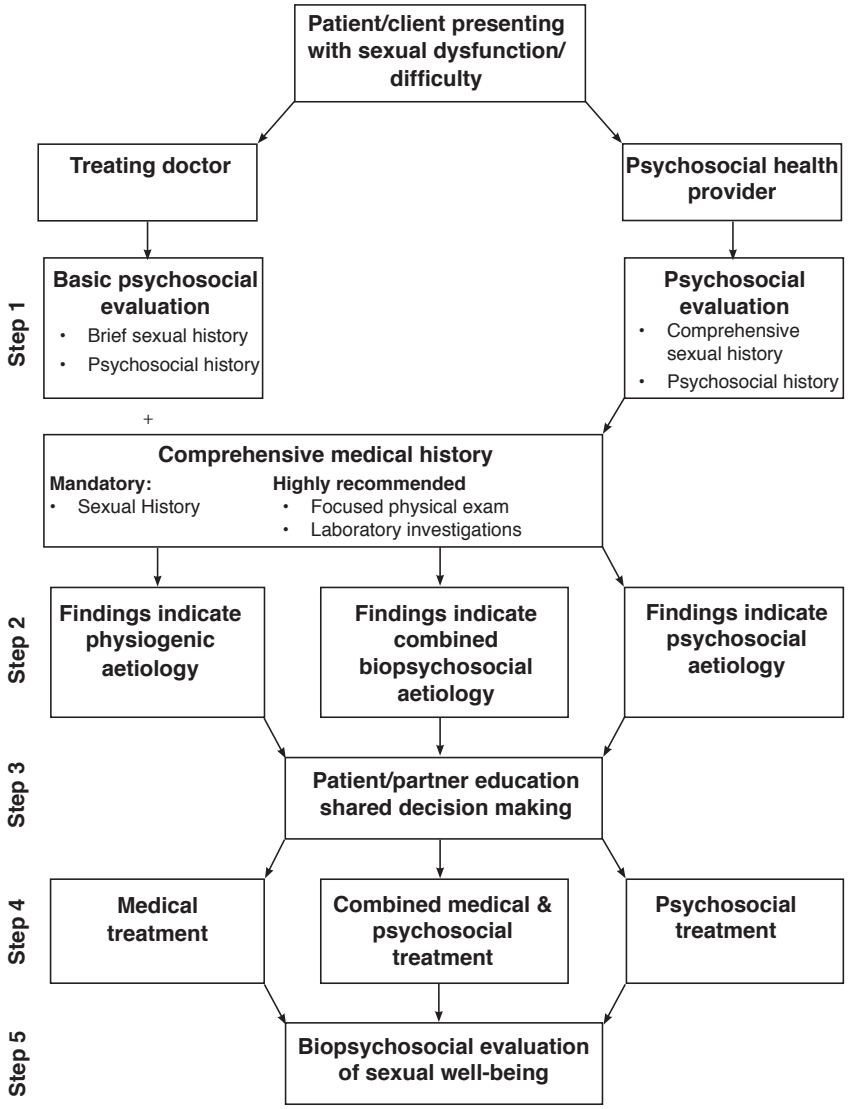
5.2.5. Discussion of Results: Integration of Medical and Psychosocial Interventions

This study found negligible evidence of formal procedures for the integration of medical and psychosocial interventions amongst psychotherapists surveyed. Interview data suggest that integration of medical and psychosocial treatments may often be contingent on: the clinician's specific training and competencies and the clinician's individual discretion on a case-by-case basis. Additionally, a number of interviewees suggest that models for the integration of medical and psychosocial interventions are a key area for further development, by virtue of the aforementioned logistical obstacles to multidisciplinary integration (Berry & Berry, 2013a). In part, this apparent deficiency is identified as a result of the high level of specialization in

healthcare professions, and the systemic separation between specialists. While intake for men with sexual difficulties may come through a number of referral pathways, the need for early medical screening in many cases of sexual dysfunction, in order to rule out or address medical concerns, is clearly defined in the research, and is explicitly recommended by 26.5% of research participants in this study. However, clear protocols and algorithms for multidimensional treatment of clients/patients amongst multiple providers are notably lacking.

Figure 5.6. (adapted from Berry & Berry, 2013a) outlines a process of care standard—inclusive of preliminary medical screening—which adheres to the International Consultation on Sexual Medicine (ICSM-5) guidelines (Lue, Basson, et al., 2004; Montorsi, Adaikan, et al., 2010; Montorsi, Basson, et al., 2010).

Figure 5.6: Biopsychosocial treatment steps. Adapted from International Consultation on Sexual Medicine, ICSM-5 Diagnostic and Treatment Algorithm (Berry & Berry, 2013a; Montorsi, Basson, et al., 2010)



A number of interviewees (14.7%) suggest that an ideal treatment system, adherent to the treatment steps outlined in Figure 5.6, would include the on-site availability of a wide range of medical, psychological, and psychosocial healthcare services. "My ideal working place," Gutteridge states,

> would be some sort of center, a holistic health and wellbeing center where I'd have free access, easy access to dermatologists, gynaecologists, obstetrician, urologists, blood tests—you know, for hormone assays and what have you—and I'd have a range of kits that I don't have to carry around round with me, from *The Joy of Sex,* the Alex Comfort book, which I use as a resource a lot, to dilators, to vacuum pumps, to whatever (research interview, 23/01/2013, transcript p. 13, lines 18-23).

From this perspective, an optimal treatment facility would include a wide variety of healthcare specialists, and an efficient and well-defined protocol for inter-professional referral. However, while this type of interdisciplinary model has been implemented in some specialist facilities, the data suggest that it is rare, and the more common occurrence is for specialists to work in "separate silos," due largely to the systemic constraints of current healthcare systems (Kirkpatrick, research interview, 29/01/2013, transcript p. 9, line 5). Given the functional separation between healthcare specialists, two particularly important biopsychosocial care strategies for psychosexual therapists, who may often work as private practitioners, or at psychotherapy-only facilities, are evident in the qualitative data:

- maintaining a strong interdisciplinary knowledge that includes a well developed understanding of the physiological aspects of sexuality, in addition to psychological and social aspects, and
- developing and maintaining an extensive referral network that includes allied health professionals from other specialities.

In addition to facilitating the assessment and referral process, a strong biopsychosocial understanding of human sexuality enables the therapist to provide effective psychoeducation to clients—a key technique emphasized by interviewees (see also section 5.5.3, below). Moreover, the development of an interdisciplinary referral network is a priority in instances where use of an integrated multidisciplinary team is impossible. Perelman has described this type of referral network as a 'virtual' multidisciplinary team (2005c). It is emphasized that the development and maintenance of a professional referral network requires vetting and homework, to ensure that allied professionals are well-trained and well-equipped to work with

sexual health issues. “Just because someone has a website, or they have an MD, or all kinds of initials after their name,” one interviewee stresses, “does not mean they’re sane and competent” (Britton, research interview, 07/03/2013, transcript p. 8, lines 1-2).

5.2.6. Discussion of Results: Integration of Psychotherapy Modalities

While biopsychosocial integration encompasses both medical and psychotherapeutic treatment, the data gathered in this study indicate that the integrative function of sex therapy extends also to the integrative use of a range of psychotherapeutic techniques, drawn from different treatment modalities. In the realm of psychotherapeutic assessment, the qualitative data reveal a widespread belief that it is necessary to gain a broad enough picture of the client’s experiences to understand the probable links between sexual functioning and other psychosocial and relational factors (McCabe et al., 2010). This type of widely scoping orientation to assessment, one interviewee emphasizes, is crucial across psychotherapeutic schools, and indicates a need for strong and diverse clinical foundations. “If you start from any type of therapy,” she contends,

> you’ve got to have a broad enough background that you don’t just approach every case as: ‘ok, this is a sex therapy case’. As I said, sometimes they came in with a sex therapy complaint, and it turned into a much more general treatment for, let’s say, depression, right? And if they came in and said they were depressed, you might have found that part of their depression was based in some pretty serious sexual difficulties, so you had to switch gears (Ravella, research interview, 11/01/2013, transcript p. 10, lines 39-44).

Respondents employ varied approaches to the treatment of related—contributing or comorbid—psychological factors, such as depression and anxiety. Many research participants, particularly those with relevant clinical training and experience provide prior or concurrent psychotherapy for comorbid conditions. Conversely, in some circumstances, interviewed clinicians prefer to treat sexual/relationship issues discretely, and may refer clients to other health providers for individual psychotherapy and/or pharmacotherapy, often before initiating treatment for sexual issues. This referral process appears to be especially common in cases of significant comorbid psychopathology where specialist skills, beyond the sex therapist’s training, are required.

Research data indicate the ethical and pragmatic need for therapists to work within the remit of their expertise and training, an issue underscored by the fact that in many jurisdictions the title "sex therapist" is not legally protected or circumscribed.[25] This point is illustrated by data from the research interviews, which identified a number of key skills that a psychosexual therapist may require in order to define an effective treatment pathway for maladaptive thoughts and beliefs, and the comorbid occurrence of related psychopathologies, in the psychosexual therapy context.

First, there is an identified clinical and ethical imperative that the therapist be qualified to identify and provide preliminary assessment of related psychopathology (Kress, Hoffman, & Eriksen, 2010; Sperry, 2011). While this capacity may not require a clinical qualification in psychodiagnostics per se, the data clearly indicate the prevalent view that the practitioner must be competent to identify signs and symptoms of psychopathology, and vigilant in monitoring for these (Rowland et al., 2014). Secondarily, in cases of significant psychopathological comorbidity it is held that the clinician must be qualified to make discretionary referrals to appropriate allied health providers (Carroll, 2011). As stated above, a considerable number of interviewees emphasize the importance of a comprehensive referral network, which may encompass mental healthcare providers assigned to work with non-sexual psychopathologies, including clinical psychologists, psychiatrists, etc. Third, the data from this study suggest that where clinicians choose to undertake the treatment of relevant psychopathologies, they must be qualified not only for treatment of said conditions, but must also have a viable clinical strategy to address how this treatment process may affect, or be affected by, the sexual therapy intervention—a particularly important consideration when working with couples. In these respects, interview data agree with current clinical guidelines, stating that, where sexual therapists and psychotherapists undertake the concurrent treatment of psychological factors alongside sexual difficulties, they must be competent to develop a treatment plan that addresses both sexual and non-sexual factors, and determine whether these aspects

[25] Nonetheless, numerous professional bodies (including those which provide the sampling frame for the specialist group in this research) offer education, training and professional development for sex therapists. In the UK, the primary professional organization for sex therapists is the College of Sexual and Relationship Therapists (COSRT), while the United States has several organizations, including: the Society for Sex Therapy and Research (SSTAR), the Society for the Scientific Study of Sexuality (SSSS), and the Association for Sexuality Educators and Counsellors (AASECT). It is also important to note that a number of professional organizations and listserves have emerged to specialize in clinical and research issues pertaining to sexual and gender diversity. In the UK, the latter include: Pink Therapy (http://www.pinktherapy.com/), and Critical Sexology (http://www.criticalsexology.org.uk/wp/).

are best treated concurrently or sequentially (Balon & Segraves, 2009; Leiblum, 2007b).

At the level of psychotherapeutic technique, many sex therapists interviewed for this research project referenced their clinical 'toolkit'—the set of therapeutic skills and techniques they utilize in the treatment of clients and patients. For most respondents, the range of clinical skills and competencies used in the treatment of men's sexual problems appears to be quite varied, drawn from a variety of therapeutic schools, suggesting that an integrative approach to psychotherapy may be very common amongst both psychotherapy generalists and sex therapy specialists working in the treatment of men's sexual problems, a finding substantiated by wider research on contemporary psychotherapy models (Grencavage & Norcross, 1990; Hawton, 1998; Norcross & Goldfried, 2005; Prochaska & Norcross, 2007; Tantam, 2006).

This qualitative finding is further substantiated by quantitative data drawn from the research questionnaire. A sizeable minority (33.3%) of questionnaire respondents identify "integrative treatment methodology" as their primary treatment methodology. Table 5.4 illustrates the self-identified treatment framework of questionnaire respondents.

Table 5.4
Self-identified primary treatment methodology showing frequency of endorsement and related percentage for all questionnaire respondents, sex therapy specialists (ST) and psychotherapy generalists (PG)

	Total Frequency	Percent (%)	Frequency (ST)	Percent (%)	Frequency (PG)	Percent (%)
Self-Identified Primary Treatment Methodology						
Integrative	53	33.3	29	33.0	24	33.8
Cognitive Behavioural Therapy	44	27.7	32	36.4	12	16.9
Psychodynamic Therapy	18	11.3	2	2.3	16	22.5
Psychoeducational Therapy	12	7.5	8	9.1	4	5.6
Systemic Therapy	4	2.5	3	3.4	1	1.4
Experiential Therapy	2	1.3	2	2.3	0	0.0
Inter Personal Therapy	5	3.1	3	3.4	2	2.8
Medical Pharmacological	3	1.9	2	2.3	1	1.4
Cognitive Analytic Therapy	1	0.6	1	1.1	0	0.0
Sex Coaching	1	0.6	1	1.1	0	0.0
Mindfulness Based Therapy	6	3.8	3	3.4	3	4.2
Gestalt Therapy	2	1.3	1	1.1	1	1.4
Humanist Therapy	4	2.5	0	0.0	4	5.6
Acceptance and Commitment Therapy	1	0.6	1	1.1	0	0.0
Psychoanalysis	2	1.3	0	0.0	2	2.8
Relational Therapy	1	0.6	0	0.0	1	1.4
Total	*159*	*100.0*	*88*	*100.0*	*71*	*100.0*

Thus, both qualitative and quantitative data obtained in this survey strongly suggest that therapists' 'toolkits' tend to be diverse and integrative, drawing on techniques from a range of psychotherapy models, and expanding through new learning, clinical experience, and professional development. Additionally, it appears that the therapist's use of a particular technique or framework may generally be dictated by a subjective assessment of their prospective utility for a particular client, at a particular

point in therapy, and contingent on the unique clinical picture (rather than a protocol-driven treatment procedure).

Verbal interviews indicate that even therapists who identify principally with a single primary treatment methodology may often use techniques from a range of different therapeutic models, with evidence of psychotherapy integration emerging explicitly in a majority (61.8%) of research interviews. Respondents also provide further data on the often ad hoc nature of technique choice, with interviewees answering the question "how would you designate your primary treatment model(s)" in a widely varied manner, but routinely indicating the value of technical eclecticism or theoretically assimilationist approaches to treatment.

Technical eclecticism is seen as an empirically-driven process in which a choice of technique is driven by what works best (Norcross, 2005, p. 5) and in which "theory becomes relatively unimportant" (Wampold, 2013, p. 21). According to Norcross, technical eclecticism entails the "use of various techniques without regard to the theory that spawned them" (Norcross, Karpiak, & Lister, 2005, p. 1589). By contrast, assimilative integration relies upon "a firm grounding in any one system of psychotherapy" (Messer, 1992, p. 151) but entails "selective incorporation of techniques and concepts from different orientations" (Norcross et al., 2005, p. 1589). Although further research is needed to determine whether a technically eclectic system of integration, or a theoretically assimilationist approach is more prevalent amongst sex therapy specialists, research data here suggest that sex therapists may work from either model of integration, with a substantial proportion of interviewees (35.3%) indicating that the treatment modality of choice is contingent on an in vivo assessment of client/patient needs. Winn, for instance, indicates an eclectic integrative approach, in which treatment of choice "varies according to the person I'm sitting with" (research interview, 16/01/2013, transcript p. 5, lines 14-15), while Alman identifies a more assimilationist orientation, identifying her primary psychotherapeutic model as "cognitive therapy," further elaborating "along with anything else that seems useful at the moment" (research interview, 09/01/2013, transcript p. 1, lines 12-13).

Analysis of the qualitative interview data indicate that it may be particularly important to distinguish between *implicit* and *explicit* psychotherapeutic integration. Interview data suggest that many clinicians may be guided by the rubric of doing 'whatever works' at any given point in the psychotherapy process, but that the process for judging 'what works' varies substantially between clinicians, and perhaps

for individual clinicians at different points in the psychotherapy process. It appears that clinicians vary substantially in terms of how systematic or formal their method of choosing a treatment methodology may be. A small proportion of interviewees indicate a highly structured treatment protocol. At the other end of the spectrum, some clinicians' choice of method/technique in session, or at a particular point in the psychotherapy process, appears to be determined largely by clinical intuition. Milrod (research interview, 10/11/2012), for instance, stresses the error-susceptibility of intuition-based practice, while Gutteridge (research interview, 23/01/2013), by contrast, emphasizes the importance of "informed intuition"—an in-the-moment form of method-based practice.

It has been noted, however, that implicit decision-making processes about treatment interventions provide little information about the criteria a clinician might use in practice. Published data suggest that in many cases clinical intuition may translate poorly into treatment practice, due to a high level of variability, and absence of clearly articulated treatment standards and pathways (Goodheart, Kazdin, & Sternberg, 2006; Margison et al., 2000; McLeod, 2001; Stewart & Chambless, 2007). Lilienfeld and colleagues have argued that over-reliance on clinical intuition is an increasing trend in psychotherapy practice, as "a growing minority of clinicians appear to be basing their therapeutic and assessment practices primarily on clinical experience and intuition rather than on research evidence" (Lilienfeld, Lynn, & Lohr, 2012, p. 1). This over-reliance on clinical intuition is problematic, Lilienfeld et al. assert, because "many practitioners tend to be overconfident in their judgments and predictions, and to fall prey to basic errors in reasoning (e.g., confirmatory bias, illusory correlation) in the process of case formulation" (Ibid. p. 3). Alongside a sub-disciplinary push for evidence-based practice in sex therapy specifically (Althof, 2010b; Althof et al., 2014), this overall trend underscores the need for clear and empirically-substantiated process guidelines in psychosexual therapy, particularly when integrating multiple methods or theories.

With respect to psychotherapy integration, Daines and Hallam-Jones argue that the absence of a unifying theory for the integration of different psychotherapy frameworks has been an obstacle for sexual health clinicians and researchers, and has in some cases compromised the theoretical rigour of the sex therapy discipline. To address this deficit, they have proposed the Multidimensional Intervention Sex Therapy (MIST) model, within which, they suggest, "a more rigorous approach to combining therapies…can be developed" (2007, 339). In addition to providing a

theoretical basis for the integration of biological and psychotherapeutic treatments, Daines and Hallam-Jones' model allows for the conceptual and applied integration of varying psychotherapeutic techniques. Evidence suggests that this type of theoretically and methodologically rigorous integrative approach has become de rigueur for many psychotherapists (Stricker, 2010). Within the sex therapy field specifically, a number of researchers and clinicians have recently begun to direct concerted attention to *self-consciously* multi-modal practice (Althof, 2010a; Bancroft, 2005; Berry, 2013b; Morrow, 2008).

When implementing multi-theory interventions, Daines indicates, it is necessary to acknowledge that integration can lead not only to complementary effects, but also to *interference* between modalities. As such, Daines and Hallam-Jones identify three integrative methods: "skills combination, sequential use of approaches and the fully integrated use of different theories" (Daines & Hallam-Jones, 2007, p. 342). These different methods are varyingly formal and protocol-driven. Sequential integration, the authors suggest,

> introduces a considerable degree of sophistication in using two theories within an overall framework. It involves the use of one theoretical approach with another model used when certain specified criteria have been met in relation to the failure of the first to resolve the issues (Daines & Hallam-Jones, 2007, p. 343).

This model may be particularly useful in the integration of psychodynamic and cognitive behavioural techniques in the treatment of sexual problems, and has be illustrated in Kaplan's stepwise model for understanding the aetiology of sexual problems, discussed below in chapter 8 (Daines, 1992; Kaplan, 1974b). Skills combination is more closely aligned with a technically eclectic model, which may be seen to favour a more implicit process for choosing a technique or intervention, although it is important to note that combination of skills and techniques can be implemented in an explicit manner consistent with evidence-based practice.

Fully integrated use of differing theoretical frameworks is seen as "the most ambitious, but also the most problematic" framework, as integration requires that the practitioner "fully retain a theoretical integrity" for all theoretical models used (Daines & Hallam-Jones, 2007, p. 343). New psychotherapy frameworks, including pluralistic counselling and psychotherapy (Cooper & McLeod, 2007, 2010) provide a systematic framework for the integration of different theories and techniques. However, "full integration," of the sort described by Daines & Hallam-Jones (2007),

may be an aspirational goal. While further research may be warranted to evaluate how (and *if*) psychodynamic and CBT techniques may be fully integrated in the treatment of sexual dysfunction, the objective of this research project is to determine how psychodynamic and CBT techniques currently are, and may be, integrated within the sex therapy field, including the combination of skills, and sequential use of differing models.

5.2.7. Discussion of Results: Integration of Psychodynamic and CBT Techniques

It has been argued that psychotherapy integration functions both as a "tendency" in clinical practice, and as a "modality in its own right" (Trijsburg et al. 2005, p. 95). The data on integrative practice amongst psychotherapists and sex therapy specialists, discussed in this section and throughout this dissertation, appear to substantiate this theory, indicating that the psychosexual and psychotherapeutic treatment of men's sexual problems is predominantly integrative. One of the primary objectives of this research is to collect data that will help guide the *explicit* and systematic, evidence-based integration of psychodynamic and cognitive behavioural methods within the integrative model of psychosexual therapy.

While cognitive behavioural methods have a longstanding explicit link to sex therapy (Hawton, 1985; Masters & Johnson, 1966), this research is predicated on the theory that psychodynamic methods may have a comparably important, but largely implicit, role. This research project aims to help identify the psychodynamic techniques that are most commonly used in sex therapy practice, either implicitly or explicitly, and the clinical and theoretical frameworks—including attachment theory and mentalization-based theory and practice—that have been influenced significantly by psychodynamic theory, which are apparent in the interview data from this study. Overarchingly, the data appear to substantiate the hypothesis that psychodynamic and psychoanalytic techniques and insights may be routinely used in the psychotherapeutic treatment for male sexual dysfunctions, within an integrative, biopsychosocial treatment model, a finding discussed in this section and throughout this dissertation.

Several sub-themes identified in the interview data suggest the prospective benefits of integrating psychodynamic and CBT techniques in the treatment of male sexual dysfunction. 26.5% of interviewees indicate that the integration of psychodynamic and CBT techniques may be beneficial in the treatment of sexual dysfunction/problems, while 17.6% indicate that they interweave psychodynamic

and CBT techniques non-sequentially (i.e. concurrently) in clinical practice. Additionally, 17.6% evince the use of psychodynamic techniques to overcome 'blocks' in treatment, where CBT has proven ineffective or inadequate (see appendices I and J). Consequently, the integration of psychodynamic and CBT techniques in the treatment of male sexual problems may comprise both sequential and concurrent integration, and may entail technical eclecticism or theoretical assimilationism for practitioners from different clinical orientations.

Green and Seymour illustrate the mutual enhancement that may be derived from using psychoanalytic and cognitive behavioural methods in conjunction; these techniques, they hold, may have a therapeutic complementarity. "The psychoanalytic approach", they state,

> can, at times, be an effective way of addressing a difficulty in the sexual relationship. However, the insight gained into the unconscious dynamics of the dysfunction does not always result in a change of behaviour. On the other hand, a purely cognitive behavioural approach might fail to effect a long-term recovery if the underlying causes of the problem are not addressed. The use of an integrated model enables the psycho-sexual therapist to formulate both psychodynamic and cognitive behavioural interventions as appropriate, thus addressing both the psyche and the soma simultaneously (Green and Seymour, 2009: 141).

In addition, Luyten and colleagues provide evidence for the positive effects of integrating psychodynamic techniques with other areas of therapeutic practice, stating that "a growing number of studies document the efficacy and effectiveness of various forms of psychodynamic psychotherapy," and noting the "growing convergence" between psychodynamic psychotherapy and other areas of psychotherapeutic research and practice, which include "developmental psychology…including attachment research" (Luyten et al., 2006). Both the qualitative and quantitative data in this study suggest that sex therapists focus significantly on the role of developmental factors, early life influences, and attachment style, in understanding and treating sexual dysfunction (see also chapter 8, below). The question, therefore, may be less *whether* there is a prospective benefit to using psychodynamic practices within an integrative sex therapy orientation, and more: how are psychodynamic practices used within such an integrative system?

One of the key themes in integrative practice, identified by research interview participants, is the tendency for the clinician's practice to evolve, and expand upon

the clinician's core training, through the integration of new techniques and methods within an expanding 'toolkit'. An apparent key element in this process is continuing professional development—increased exposure to a variety of therapy modalities through advanced an ongoing training, and through dialogue with peers and colleagues (Kleinplatz, 2009). Another part of this professional development process appears to be clinical experience—learning 'what works, for whom' through n=1 studies, and trial-and-error experience (Masters & Johnson, 1970, p. 1; McCarthy & McDonald, 2009b). As data presented in the following chapters illustrate, clinicians largely appear to be more focused on process and outcome than on methodological purism. Dunn exemplifies this approach, in stating,

> somebody said that successful therapy is really the therapist telling the patient a story. If the patient and the therapist agree on the story, the treatment progresses and does well. So, it doesn't matter if it's a psychodynamic story, a behavioural story, a cognitive story. Whatever the story, if the therapist believes it and the patient believes it, the therapy progresses. So, I don't know. I have a colleague at the medical school who was trained very behaviourally, very behaviourally, ok? But over the years he's picked up some of the psychodynamic stuff, so he's a mixture too now. Even though his approach is still very behavioural, he will describe a case and he'll describe it in psychodynamic terms (research interview, 29/01/2013, transcript p. 9, lines 39-46, p. 10, lines 1-2).

One of the emergent messages in this research project is that the highly publicized doctrinarian tensions between psychodynamic and cognitive behavioural approaches, found in much scholarship and disciplinary politicking, may be of limited applicability in clinical psychosexual therapy.

Data from this study, described in greater detail in the following chapters, also indicate that in many cases cognitive behavioural and psychodynamic techniques specifically—the primary models under consideration in this research—may be used conjunctively and complementarily. "Sexuality," Tiefer stressed in a personal correspondence,

> lends itself to the same psychodynamics as every other part of life, relationship and personality—symbolism, psychological defenses, habit-formations, traumas, etc. I use cognitive and behavioral psycho-education with my patients to help them change their distressing patterns, but it is informed by ongoing discussions of meaning, family origins, and always

analogies to other aspects of their lives to demystify sex (personal communication, September 22, 2012).

Overall, analysis of data collected in this study suggests that single-modality approaches—which Trijsburg et al. (2005) have described as "therapeutic monism"—are not the norm in sex therapy. Rather, both the quantitative and qualitative evidence obtained in this research project indicate that, as outlined in table 5.4 above, psychotherapeutic integration may be the most prevalent theoretical orientation amongst both psychotherapy generalists working in the treatment of male sexual dysfunction (33.8%), and amongst sex therapy specialists (33.0%). Both qualitative and quantitative data presented in the following chapters suggest that research participants draw considerably on a combination of psychodynamic, cognitive behavioural, social constructionist, and other psychotherapeutic modalities, in the diagnosis, assessment and treatment of male sexual problems.

5.3. Does it Take Two to Tango? Integration of the Partner into Biopsychosocial Sex Therapy

An overview of current research (see chapters 2 and 3), suggests that sex therapy specialists often conceive of, and treat, psychosexual issues, from within a couple/relational framework. Metz and McCarthy's "good enough" sex model (identified above), for instance, takes a largely relationship-based orientation to sex therapy (McCarthy & Thestrup, 2009b; Metz & McCarthy, 2007). Additionally, the development of a systemic sex therapy model (Hertlein, Weeks, & Gambescia, 2009; Hertlein, Weeks, & Sendak, 2009), reflects the influence of a number of core principles that appear foundational to much sex therapy work, as reflected in the data gathered in this study. Amongst the foundational principles of the systemic sex therapy model are the beliefs that:

> (1) sexual problems may reflect problems at many different levels in the couple ranging from lack of communication to underlying intimacy problems, (2) the resolution of the couple's problems are necessary to remedy many sexual problems, (3) unconscious factors in the couple's relationship may impede or sabotage the couple being able to develop a more satisfying sexual relationship, (4) a sexual problem in one partner may 'mask' a sexual and/or relational problem in the other, [and] (5) the sexual problem may be unconsciously maintained by the couple (Hertlein, Weeks, & Gambescia, 2009, p. xii).

These guiding systemic therapy principles are prevalent themes within the qualitative data in this study, suggesting that a systemic psychotherapy orientation—which seeks to address the dyadic sexual relationship as a site of potential therapeutic change—may be a distinguishing characteristic of contemporary sex therapy.

Based on published research that positions the couple relationship as central within the treatment of male sexual dysfunction, this research project sought to determine: *to what extent do sex therapists utilize a couple framework in clinical practice?* Here, potential differences in the degree to which sex therapy specialists approach male sexual dysfunction from a couples' therapy standpoint, as opposed to psychotherapy generalists are evaluated, in order to determine the extent to which a couple-therapy approach may characterize contemporary sex therapy practice.

5.3.1. Does it Take Two to Tango? Questionnaire Results

The questionnaire asked respondents (1) how often they use a couples' counselling approach in treating male sexual problems in general, and (2) to what extent they used a couples' counselling approach in the most recent relevant case of male sexual dysfunction they treated. Table 5.5 and figures 5.7 and 5.8 indicate the degree to which specialist sex therapists and psychotherapy generalists report using a couples' psychotherapy approach, on average, and with their most recent relevant client.

Table 5.5
Respondents' use of a couples' counselling approach, showing average use and use with most recent client for all questionnaire respondents, sex therapy specialists (ST) and psychotherapy generalists (PG)

	Total Frequency	Percent (%)	Frequency (ST)	Percent (%)	Frequency (PG)	Percent (%)
Average use of couples' counselling approach						
Never	20	12.6	0	0.0	20	28.2
Occasionally	36	22.6	8	9.1	27	38.0
As often as not	25	15.7	13	14.8	12	16.9
Usually	54	34.0	44	50.0	10	14.1
Always (Where possible/Applicable)	24	15.1	23	26.1	1	1.4
Total	*159*	*100.0*	*88*	*100.0*	*71*	*100.0*
Use of couples' counselling approach with last client						
Not at all	49	30.8	12	13.6	37	52.1
Somewhat	13	8.2	4	4.5	9	12.7
Moderately	14	8.8	6	6.8	8	11.3
To a significant degree	43	27.0	31	35.2	12	16.9
To the maximum possible degree	40	25.2	35	39.8	5	7.0
Total	*159*	*100*	*88*	*100*	*71*	*100*

Figure 5.7 shows a frequency distribution of interview participants' responses to the question "In treating men's sexual dysfunctions, how often do you use a couples' counselling/psychotherapy approach (i.e. counselling both members of a couple, either separately or together)?", measured on a five point Likert scale ranging from "never" to "always". An independent sample t-test was performed, which

demonstrated that sex therapy specialists ($M = 3.93$) report a significantly higher average level of adherence to a couples' counselling approach, overall in their practice, relative to psychotherapy generalists ($M = 2.21$), $t(157) = 11.207$, $p < .001$.

Figure 5.7: Respondents' reported average use of a couples' counselling approach, for all questionnaire respondents, sex therapy specialists and psychotherapy generalists

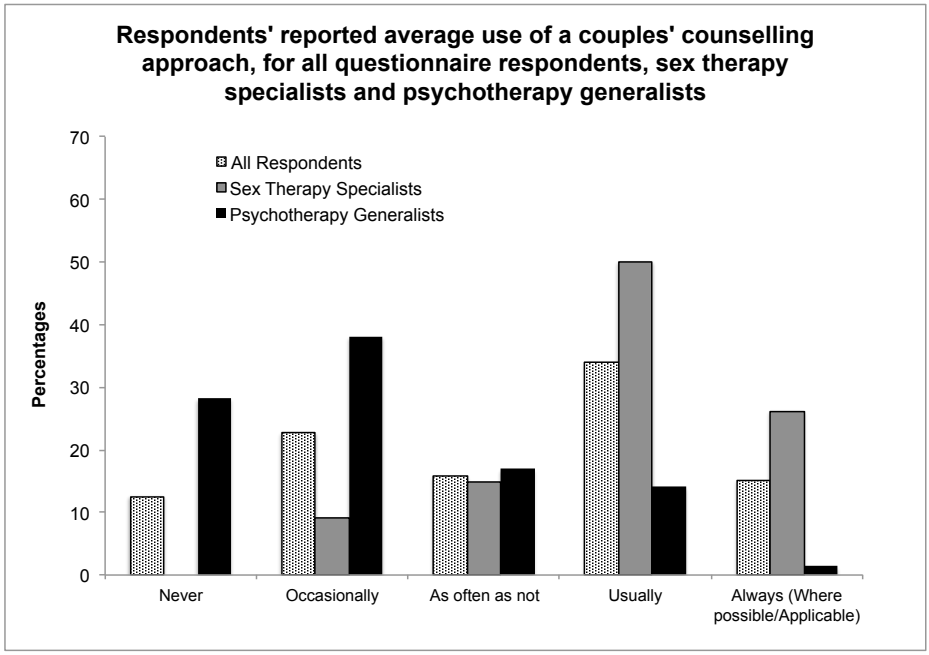
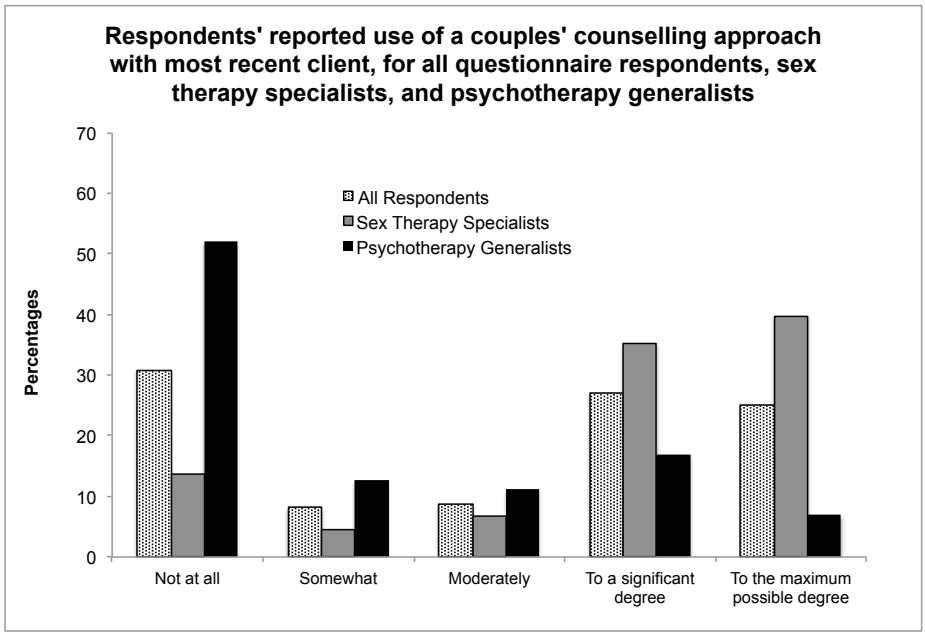


Figure 5.8 shows a frequency distribution of interview participants' responses to the question "With the most recent relevant patient (i.e. patient with a partner), to what extent did you use a couples' counselling/psychotherapy approach?" measured on a Likert scale ranging from "not at all" to "to the maximum possible degree". An independent sample t-test was performed, which demonstrated that sex therapy specialists ($M = 3.83$) show a significantly higher average level of self-assessed adherence to a couples' counselling approach relative to psychotherapy generalists ($M = 2.14$), with their most recent relevant client, $t(157) = 7.670$, $p < .001$.

Figure 5.8: Respondents' reported use of a couples' counselling approach with most recent client, for all questionnaire respondents, sex therapy specialists, and psychotherapy generalists



Considering all respondents, approximately half (49.1%) report using couples' counselling "usually" or "always", on average in their clinical practice, and approximately half (52.2%) report using couples' counselling to a significant, or maximum possible degree with their most recent client.

It is very important to note, however, the significant divergence between the proportion of sex therapy specialists, and psychotherapy generalists, respectively, who report using a couples' counselling approach on average and with their most recent male client. A majority of sex therapy specialists (76.1%) report using a couples' counselling approach "usually" or "always" with their male clients. However, a minority of psychotherapy generalists (15.5%) report using a couples' counselling approach "usually" or "always" with their male clients. Similarly, while a majority of sex therapy specialists (75.0%) report using a couples' counselling approach to a significant, or maximum possible, degree with their most recent client, a minority of psychotherapy generalists (23.9%) report using a couples' counselling approach to the same degree. These findings are underscored by the fact that, amongst psychotherapy generalists, a majority (66.2%) report using a couples' counselling approach "never" or "occasionally", and a small majority (52.1%) report using a couples' counselling approach "not at all" with their most recent male client.

5.3.2. Does it Take Two to Tango? Qualitative Interview Results

Interview data appear to substantiate, and lend further detail to, the questionnaire results outlined above, with research participants emphasizing the importance of addressing the often-complex interplay between sexual problems and wider relationship factors. Tables 5.6 and 5.7 (presented in appendices K and L) describe the key themes, relevant to a couple-oriented treatment approach, in the qualitative research interviews.

Partner and relationship issues were a prominent thematic area. Emphasis on a couples-based approach is high amongst clinicians surveyed in this research project; a considerable number of interview participants (47.1%) indicate that they conceptualize the client's problem in a social/interrelational way, especially focusing on the couple relationship. Sub-themes in this area include: emphasis on the advantages of framing the problem as a couple issue, focusing on blame (between couple members) as a key factor in sexual problems, working with non-sexual relationship problems that may present as (or intensify) sexual problems, and the role of communication as a mediating variable in the sexual problem.

A high proportion of interviewees hold that the client's partner (in cases in which the client is in an ongoing sexual relationship) ideally will have a high level of involvement in the therapeutic process, both in the assessment and conceptualization of the sexual difficulty, and in the ongoing therapeutic work. A considerable number (35.3%) of interviewees emphasize the importance of seeing both members of a couple during *assessment*, while the same number (35.3%) indicate using a couple-based *treatment* approach that actively involves both members of the couple. The overarching theme for many sex therapy specialists appears to be: a maximum level of collaborative partner involvement is, in most cases, desirable in the treatment of male sexual dysfunction.

Overall, interviewees stress the interaction between sexual difficulties and wider relational factors. "It's a hoary old stereotype" Gutteridge states, "but relationship problems are often played out in the bedroom, and the skill in psychosexual therapy assessment is to determine which of [these factors], the inside or outside the bedroom, is actually the major problem" (research interview, 23/01/2013, transcript p. 11, lines 30-33). Another complicating factor, apparent in the qualitative data, is the complex presentation of sexual issues, and the possible variance between the presenting sexual problem and the unrecognized—and often

unconscious—variables that may contribute to or underlie the sexual problems in the couple relationship. As one interviewee states,

> you're going to get a lot of referrals that present as a sexual problem, but really when you scratch are not going to be a sexual problem. Just like when I was practicing as a general therapist, there were a lot of people that came in with quote 'marital disharmony' that had sexual problems. So, chief complaints at first visits, frequently, are not what you're going to be dealing with primarily, in the course of therapy (Ravella, research interview, 11/01/2013, transcript p. 5, lines 6-11).

It is important to note that a significant number of interviewees advocate an integrative psychosocial orientation in which sexual relationship issues, wider relationship issues, and individual psychological factors are seen as inherently and intimately interlinked.

Several sub-themes in the research interviews attest to the challenges of psychosexual therapy in the couple context. Research interviewees stress that—particularly by virtue of the significant amount of psychoeducation and behavioural homework used in sex therapy (Leiblum, 2007b; Wincze & Carey, 2001)—the couple relationship must be stable/robust enough for cooperation and communication between the partners. Additionally, a number of interviewees (26.5%) emphasized the value of seeing couple members both together and separately during assessment, in order to gain a clearer, more accurate understanding of the presenting concern. Three related sub-themes—1) the apparently common presence of secrets between couple members, 2) the possibility that couple members hold divergent sexual values and, 3) the increased likelihood of disclosure during a one-to-one meeting with the therapist—appear to underlie this strategy.

Finally, it is important to note the high level of emphasis placed on the interaction between intimacy and sexuality in the couple relationship. 20.6% of interviewees stressed the importance of relational intimacy for sexual functioning. One apparent sub-theme was the perceived difference or tension between intimacy and sexuality/eroticism in the couple's interaction; reconnecting the couple, or building intimacy, was stated as an explicit, overarching therapeutic aim in couple work for a substantial number of interviewees. "When I think of healthy relationship," McCarthy states, "it integrates satisfaction, stability and sexuality. And I think if you're going to do that, you've got to integrate intimacy and eroticism" (research interview, 17/01/2013, transcript p. 8, lines 45-46, p. 9, line 1).

In sum, an apparent overriding objective for psychosexual therapists working with relational issues may be the functional integration of sexuality and intimacy/companionship (an issue discussed at greater length in chapter 8).

5.3.3. Discussion of Results: Does it Take Two to Tango?

With romantically/intimately-partnered clients, there is a broad agreement, apparent in both the qualitative and quantitative data, that the couple relationship is of overarching importance. Consequently, a couple-oriented approach is considered a crucial theme in the research data, and it is important to note that this finding agrees with much of the published research, which suggests that the couple-orientation is a well-established and long-standing clinical practice. A couple-based treatment orientation has an enduring place in psychosexual therapy, and was standard practice for Masters and Johnson, and many subsequent practitioners (Hertlein, Weeks, & Gambescia, 2010; Masters & Johnson, 1970). More recently, Leiblum has asserted that "sex therapy is fundamentally *couple* therapy—without including the partner, crucial information is lost and therapeutic outcome is compromised" (2007a, p. 8). By virtue of the high priority placed on the couple relationship, couple counselling focusing on wider relationship issues—including communication, the partners' respective perspectives on the role of sex in their relationship, and extraneous biopsychosocial factors that may affect sexual behaviour—may often be necessary. The male client may initially present for treatment alone, especially when intake is through a medical doctor, and it may be noted that the dominant psychiatric diagnostic frameworks are categorically individual (American Psychiatric Association, 2000, 2013; World Health Organization, 1992, 1993). However, published research suggests that partner involvement is an important predictor of treatment outcome (Berry & Berry, 2014; Chevret-Measson et al., 2009; Dean et al., 2006a, 2006b; Dean et al., 2008; Fisher, Eardley, McCabe, & Sand, 2009). Consequently, the data in this study, and the wider literature alike, support the interpretation that strategies for including the partner in the treatment programme are a high clinical priority.

A number of salient themes in the research interview data, described above, underscore the importance of involving the partner in the treatment process, and, as described above, both quantitative and qualitative data in this study suggest that a many sex therapy specialists work largely within a couple-oriented framework in assessment, treatment or both. In fact, a common adage in relationship-based

therapy is that: the relationship itself is the client (Davis, Lebow, & Sprenkle, 2012). Seymour emphasizes a tendency, prevalent amongst interviewees and questionnaire respondents, to focus on sexual dysfunction as a couple issue, rather than an individual dysfunction, stating:

> what we would say…is: it's not him and it's not her (if we're dealing with a heterosexual couple), our client is the relationship that goes between the two. So we're always trying to frame it as a couple issue (research interview, 04/07/2013, transcript p. 15, lines 15-17).

These data support the hypothesis that a significant proportion of sex therapists may conceive of sexual problems/dysfunction per se as a relationship issue, and, consequently, frequently use a couple counselling approach in the treatment of male sexual problems.

In fact, this research supports the interpretation that, in working with a client who is in a partnered relationship, the inclusion of the partner may be seen as one of the principal categories of integration in sex therapy (Berry & Berry, 2014). In this regard, a considerable body of previous research suggests that, amongst heterosexual couples, the female partner's involvement in the treatment process is an important determining factor in treatment outcome (as subjectively assessed by the client/patient) (McCabe et al., 2010; McCarthy & Thestrup, 2009a). Additionally, critical sex therapy researchers have noted that the relational aspects of sex therapy are of comparable importance for clients who are not in a heterosexual relationship, including many LGBTQ clients and clients who are in openly non-monogamous relationships, though it is important to note that working with sexual diversity may often require specific clinical skills—an issue addressed in chapter 7, sections 7.2-7.2.5 (Barker, 2011b; Barker & Langdridge, 2008, 2010b; Bigner & Wetchler, 2012). Overall, questionnaire and interview data obtained in this research project appear to substantiate this body of research, and highlight the importance of relational factors as a component in biopsychosocially-oriented sex therapy.

These data also appear to substantiate the hypothesis that a couple-counselling orientation is a distinguishing characteristic of sex therapy practice. Thematic analysis of research interviews identified a number of clinical strategies for involving the partner, and working with the couple relationship, where the client initially presents for individual treatment. They can be loosely categorized as:

1) psychoeducation of the male client about the role of the couple relationship and strategies for communicating with his partner,

2) clinical consultation with the partner (i.e. by the therapist), and
3) couple-based psychoeducation and counselling/treatment.

These strategies may conform to a stepwise intervention protocol, which involves the partner to an increasing degree, dependent on the persistence of the sexual difficulty, and logistical factors, including the partner's willingness to be involved in the treatment process. Additionally, it is important to note that, where possible, many sexual therapy specialists may wish to initiate relationship-based therapy (i.e. actively/directly involving both partners) from the outset of treatment.

Psychoeducating the client who presents for individual treatment may be an efficacious first step in the treatment course, and can be implemented by both psychotherapists and medical practitioners (Berry & Berry, 2014; Phelps, Jain, & Monga, 2004). This psychoeducational process entails informing the patient about significant partner and relationship variables in the dysfunction and its treatment, and strategies for recruiting the partner as a treatment support, or otherwise involving the partner in the treatment process; this entails helping the patient to understand how relationship factors, and external factors that impact relational dynamics, can affect the sexual aspects of the relationship (McCarthy & Fucito, 2005; Perelman, 2003). Additionally, psychoeducation may focus on techniques the patient can use in communicating with the partner about the dysfunction and the proposed treatment course. Interview data indicate that one of the main objectives of this communication process, which the clinician may prioritize in discussion with the client, is gaining partner buy-in and participation. As stated above, current research confirms that partner involvement is a predictor of successful outcome in the treatment of male sexual dysfunction, and data from this research project indicate that psychoeducation focusing on partner involvement may be an effective first step in the treatment process (Kukula, Jackowich, & Wassersug, 2013).

Involvement of both couple members *throughout* the treatment process was a prominent theme in the qualitative data. The data suggest that, where possible, involving the client's partner in the treatment process through direct clinical consultation increases the likelihood of a positive treatment outcome. This extends to the increased likelihood of collaborative couple work, and also to the establishment of realistic, couple-based treatment goals (an issue discussed at length in chapter 7). Extant data suggest that where the client seeks treatment without communicating with his partner, treatment outcomes may be compromised (Leiblum, 2007a; Lue, Giuliano, et al., 2004; McCabe, 2001; Montorsi, Adaikan, et al., 2010).

Consequently, one aim of partner consultation is to ascertain whether the partner's sexual and relationship goals are consistent with the client's goals. As identified above (section 5.3.2.), an approach that appears to be commonly used, particularly in assessment and case formulation, is to offer consultation to the members of the couple both together *and* individually, on a number of occasions, on the basis that this consultation procedure may counteract relationship challenges identified above—including secrets and divergent sexual wants or values between couple members. The underlying assumption is that the partner may feel more comfortable disclosing certain information to the healthcare provider privately (i.e. without the client present), creating a higher propensity for honest disclosure during a one-to one session.

A third, and more intensive strategy, for involving the partner in the treatment process entails the use of a fully or primarily couple-based psychotherapy, either relationally-focused (i.e. couple counselling), sex-therapy oriented, or both. Although a number of interviewees (20.6%) suggest a high level of overlap between couple-based psychosexual therapy and couple counselling, interview data shows a common tendency for clinicians to differentiate between couple counselling and sex therapy per se—especially for clinicians who view behavioural interventions as primary techniques in psychosexual treatment. This differentiation frames sex therapy as focused on the treatment of sexual problems specifically, and inclusive of a number of sexual-behavioural intervention strategies (esp. sensate focus exercises). Within this model, couple counselling may be implemented either concurrent to sex therapy, or—in cases marked by significant relationship problems—prior to beginning dedicated psychosexual therapy. In clinical practice, Plaut emphasizes,

> sometimes you just put the sex aside and work with the relationship issues because that's what really needs attention. There's no way they're going to get into bed until they start liking each other (research interview, 17/01/2013, transcript p. 5, lines 42-45).

A significant sub-theme amongst research participants is the importance of effective communication strategies, and a functional level of relationship accord, as foundational to sex therapy success. As illustrated throughout this chapter, a number of interviewees stress that a high level of partner collaboration is required for successful sex therapy outcomes. Consequently, a high level of partner communication, and mutual buy-in and participation, are seen as prerequisite to many sex therapy interventions.

In some cases, therefore, before sex therapy interventions (especially couple-based behavioural exercises) can be undertaken, it is necessary to arrange couple counselling—in order to address wider couple or relationship issues, such as relationship disharmony, limited communication, or an inability to work cooperatively towards the sex therapy goals—or treatment for an individual problem—such as a psychopathology that affects sexual functioning, or an addiction or substance dependence—that may prevent a successful sex therapy outcome (Perelman, 2005a). In determining couples' suitability for sex therapy, and specific therapeutic needs, interviewees recommend conducting a focused evaluation of a number of important factors, including: possible incompatibilities in the couple's sexual desires and styles, the presence of an uncommunicated or unspoken desire (i.e. for something outside the couple's current repertoire, or conversely aversive feelings towards some unwanted element within the couple's current range of sexual activities) in one or both partners and deceit or infidelity in the relationship that may impact on sex therapy process. Interviewees also emphasize the need to assess couple and relational factors that may affect both the sexual and non-sexual elements of the relationship, indicating *blame* as a key factor. Williams states, "there's a lot of blaming in couple work. So, you know, it's all: 'if he'd change,' or 'if she'd change, we'd be alright. If you could get her to do this, we'd be fine'" (research interview, 15/01/2013, transcript p. 3, lines 41-42). Britton suggests two clever monikers, useful in conceptualizing the processes of blaming and denial of responsibility in relationship-based sex therapy: "the blame game" and "the complain game" (research interview, 23/02/2012, transcript p. 3, lines 10-12). The blame game involves "blaming someone else for what you're responsible for," while the complain game is a similar, but more deeply entrenched relationship pattern "intrinsic in many couples' relationships…it's pointing a finger at the other person and not taking responsibility for yourself" (Britton, research interview, 23/02/2012, transcript p. 3, lines 10-13).

The data indicated the importance of early identification of patterns of blame, and denial of responsibility, and early intervention, including calling clients' attention to these patterns and working with these aspects either in a relationship therapy setting prior to sex therapy, or conjunctively with sex therapy. Overall, it is generally asserted that it is necessary to closely examine relationship factors, to determine where sexual problems fit within the couple relationship, and proceed accordingly, often working on relationship and communication factors first. The

work undertaken in sex therapy with couple clients is widely understood to often require a relatively high level of relationship stability and permanence, a high level of mutual commitment to process, and relatively sophisticated communication skills.

It is important to note, however, that sex therapy clients are heterogeneous with respect to relationship status. While it appears that a substantial proportion of sex therapy clients may be in long-term one-to-one relationships, some are in shorter-term relationships—which may have begun recently—some are in openly non-monogamous relationships, and some are not in an ongoing sexual relationship at the time of treatment. A number of possible strategies are suggested for working with unpartnered clients, including possible conferral with family members—to gain outside information on the client, which a sexual/relationship partner might otherwise provide (Winn, research interview, 16/01/2013)—and use of a paid surrogate partner (Savage, research interview, 04/11/2012; Resnick, research interview, 09/11/2012; Alman, research interview, 09/01/2012). Working with a surrogate, Alman states, can be of particular utility for sexually inexperienced clients, as it affords an opportunity to learn sexual and relational skills, and can help instil confidence (research interview, 09/01/2013).[26]

A clinical practice—advocated by a majority of interviewees as a foundational principle of sex therapy practice—is a non-prescriptive approach, based on the recognition that "there are no 'shoulds'," and that a successful outcome is ultimately contingent on the unique priorities and subjective satisfaction of the client, or couple (Plaut, research interview, 17/01/2013, transcript p. 6, line 19). For an apparent majority of therapists surveyed, then, sexual problems are determined through internal factors within the couple relationship, not through assessing the couple in relation to a predetermined quantitative or qualitative metric of sexual wellbeing.[27]

A number of interviewees (26.5%) stress that a particularly common source of sexual difficulty is when a qualitative or quantitative difference in sexual desire exists between members of a couple. It appears that problems are often seen where the members of the couple differ in the frequency of their desire for sex, or where there is a strong dissonance between the types of sex that they desire. The latter may translate into discomfort with a partner's sexual behaviours, with disagreements

[26] It is important to note, however, that the use of surrogate partners is a technique of significant controversy in the sex therapy field, with clinicians and researchers debating both the efficacy and ethicality of surrogate therapy (Binik & Meana, 2009).

[27] The techniques used in defining subjective, client- or couple-specific goals are addressed at length in chapter 7.

about pornography use being an apparently common example (Mark & Murray, 2012; Muise, Impett, & Desmarais, 2013; Seavey, research interview, 01/02/2013). "When the problems come in" Plaut states, "is when there is an incompatibility between the two partners, or something isn't working in one of them" (Plaut, research interview, 17/01/2013, transcript p. 6, lines 22-24). Plaut provides a case study that illustrates the complexity of sexual problems within a couple relationship, and the potential value of working from a couples therapy perspective:

> The main thing is to, I think, as little as possible put something in a confined box, and work with the whole experience of the couple, and do what needs to be done. Often, the couple presents with more than one symptom. I mean, the first couple I ever treated in sex therapy presented with erectile dysfunction. The man was a Catholic, he had a divorce, he felt guilty about the divorce and he was having difficulty with erections with his new female partner. In the course of doing the evaluation I learned that she was having painful intercourse because she was not lubricating well. It had to do, in her case, with taking antihistamines for allergies, which dry up everything. People often don't know that. And so prescribing a lubricant, or recommending a lubricant, did the trick for her at least. It may not for every woman. But, all of a sudden we have two issues, one for each member of the couple, and so you have to work with both of them. Often, there are a number of things compounded on each other—it could be relationship issues, there could be other things going on in the family, there could be job stresses—that's one of the reasons I've never gotten bored with this work. Because, I used to wonder: alright, you've only got 8 or 9 diagnostic categories, you're going to get bored working with the same thing all the time. It's never that way. Every couple is unique. Every couple has their own story, and every couple is a new challenge (Plaut, research interview, 17/01/2013, transcript p. 2, lines 12-30).

Ultimately, the findings presented in this chapter reveal the salience of couple- and relationship-based clinical techniques, within the data from this study. In response to the question—does it take two to tango in sex therapy?—in this research project the data suggest the answer for many clinicians is a resounding 'yes'.

5.4. Biopsychosocial and Integrative Practice: Summary of Findings

Data presented in chapter 5 suggest that, despite the prevalent assertion that the biopsychosocial model is highly important, clinicians express a somewhat lower level of self-reported adherence to the biopsychosocial model on average and with their most recent client in clinical practice. Consequently, the use of the biopsychosocial model is, as noted elsewhere, an important frontier for further research (Berry & Berry, 2013a). It is, however, clear that psychosocial variables—in particular relational factors—are highly emphasized by clinicians. The findings outlined in this chapter suggest that attention to the couple relationship, and some level of inclusion of the client's sexual partner (and/or conceptualizing the couple relationship itself as the client) may be a distinguishing feature of the sex therapy specialization. Additionally, the data indicate a strong trend towards inclusion and integration within the sex therapy field in a number of respects, including integration of physiological and psychotherapeutic treatments and integration of varied psychological and counselling models. In sum, the data suggest that sexual therapists set biopsychosocial integration as an aspirational goal and endorse a high level of focus on relationship variables and couple aspects in clients' sexual problems. However a key question remains: how do therapists evaluate and conceptualize clients' presenting problems? The following chapter aims to address this question, presenting data on the ways in which psychosexual therapists understand, assess, and diagnose male sexual dysfunction.

CHAPTER 6. HOW PSYCHOSEXUAL THERAPISTS UNDERSTAND MEN'S SEXUAL PROBLEMS: DIAGNOSTIC FRAMEWORK AND ASSESSMENT PROTOCOLS

6.1. Introduction: Conceptualization of Diagnosis and Diagnostic Categories

The pilot-testing phase of this research project provided an invaluable correspondence with an emeritus clinician, Dr. Michael Parish, whose four decades of experience as a sex therapist are complemented by a keen insight into the challenges of psychosexual diagnosis. "There are," Dr. Parish stated, "no such thing as sexual dysfunctions" (personal communication, May 10, 2011). Instead, he holds, sexual problems are *symptoms*, consequent upon other—often combined—biological, psychological and social factors. From this perspective, discussed in this chapter and

in chapter 7, sexual dysfunctions may be markers of organic illness, the outcome of other psychopathologies or sub-threshold psychological problems, or the consequence of underlying relationship factors (Berry & Berry, 2014). This research project evaluates the hypothesis that, in most cases, the aetiology of sexual dysfunction involves some combination of these elements, a theory that finds a very high level of support in the wider research, as indicated in chapter 3 (McCabe et al., 2010; Montorsi, Basson, et al., 2010; Perelman, 2005a, 2005c). By virtue of the complex interplay of aetiological factors, and the critical view many clinicians take of psychiatric nosology, the categorization and diagnosis of sexual problems are areas of significant debate.

The rationale for this chapter is to illustrate how clinicians conceive of sexual problems and engage with current diagnostic categories, on the basis that, in order to understand how clinicians *treat* sexual problems it is inherently necessary to first understand how they *conceive of* and *assess* sexual problems. To this end, this chapter outlines the data from this research project on the diagnostic and assessment protocols used by psychotherapists and sex therapy specialists working in the treatment of male sexual dysfunction.

Overarchingly, the data indicate that psychotherapists and counsellors vary widely in their level of adherence to standardized nosological tools, as represented in the *Diagnostic and Statistical Manuals* of the American Psychiatric Association (1952, 1968, 1980, 1987, 1994, 2000, 2013), and in the *International Classification of Diseases*, published by the World Health Organization (World Health Organization, 1992, 1993). This research project found no evidence that psychotherapists and sex therapists adhere strictly to standardized diagnostic categories in their work with male clients. Instead, there is significant evidence that many sex therapy specialists take a highly critical view of psychiatric diagnostic categories, and many research participants expressed concerns about the arbitrariness of diagnostic criteria and cut-points, the perceived artificiality of distinguishing between particular disorders, and, in some cases, the absence of an underlying aetiological theory (Barker, research interview, 30/03/2012; Braun-Harvey, research interview, 15/11/2012; Britton, research interview, 07/03/2012; Levine, research interview, 08/01/2013).

In fact, data from both the questionnaire and research interviews suggest that, for some psychotherapists and sex therapists, diagnostic categories are of dubious validity and limited usefulness, and tend to be utilized critically and, for many,

sparingly. Despite the apparently prevalent view that diagnostic categories are widely flawed, many research participants hold that clinical practice requires a diagnostic protocol, with some form of categorical framework. While this study produced no evidence that clinicians adhere strictly to a single diagnostic framework, there is evidence that many psychotherapists and sexual therapists make use of psychiatric diagnostic categories in some capacity, a theme explored throughout this chapter.

Overall, however, the data collected in this study suggest that, despite the perception that standardized models of psychiatric diagnosis are inherently limited, many clinicians hold the view that diagnostic categories have a number of pragmatic functions. The data suggest that many psychosexual specialists use diagnostic categories, including *DSM-IV-TR* and *DSM-5* diagnoses, critically, with close attention to their limitations. Amongst clinicians surveyed, standardized diagnostic categories and terminology appear to be used variously as: a non-binding conceptual 'short-hand' for interpreting the client's symptomatology, a shared lexicon for communicating with other health practitioners, including general practitioners, a conceptual tool for helping patients (and, in some instances, clinicians themselves) understand the presenting concerns, and in some cases, to fulfil the procedural requirements of a private or public health service/employer or insurance company, and for research applications including randomized clinical trials (i.e. to include or exclude patients) (Barker, research interview, 30/03/2012; Kirkpatrick, research interview, 17/01/2013; Openshaw, research interview, 26/02/2013). Hence, against the backdrop of diagnoses' accepted limitations, this chapter outlines the data on the diagnostic and assessment protocols that are used to fulfil these functions, in the treatment of male sexual dysfunction.

6.2. Diagnostic Overview: Diagnostic Framework Used in this Study

Throughout the quantitative data collection phase of this research project, *DSM-IV-TR* was in use, and served as the model of psychiatric diagnosis for the development of the questionnaire component of this study (American Psychiatric Association, 2000). At the time of writing, *DSM-5* has only recently been published. This section provides an overview of the sexual dysfunctions presented in both *DSM-IV-TR,* and *DSM-5*. The chapter illustrates some of the limitations of these diagnostic categories in this chapter, and aims to provide an overview of how male sexual dysfunction is generally conceived and assessed by psychosexual therapists.

It is important, however, to once again state that sex therapists differ significantly in their conception of both diagnostic categories and practices, and it is necessary to be cautious about over-generalizing in this area.

While the *DSM-IV-TR* diagnostic criteria were the primary framework examined in this study, it is noted that these diagnostic categories are largely consistent with the model used in the World Health Organization's *International Classification of Diseases,* 10th edition (*ICD-10*). The *ICD-10* describes sexual dysfunction as "a psychosomatic process" that involves both psychological and physical dimensions; according to this standard, the designation "sexual dysfunction" encompasses "the various ways in which an individual is unable to participate in a sexual relationship as [they] would wish" (1993, p. 191). The research questionnaire used in this study inquired specifically about clinicians' experiences in treating five core male sexual dysfunctions defined in *DSM-IV-TR*: hypoactive sexual desire disorder (302.71), sexual aversion disorder (302.79), male erectile disorder (302.72), male orgasmic disorder (302.74), and premature ejaculation (302.75) (American Psychiatric Association, 2000, pp. 538-554). Table 6.1 illustrates the diagnostic categories for male sexual dysfunction, in *DSM-IV-TR* and *DSM-5.*

Table 6.1
Sexual Dysfunction Diagnostic Categories in *DSM-IV-TR* and *DSM-5* (Adapted from American Psychiatric Association, 2001, pp. 535-566, and American Psychiatric Association, 2013 pp. 423-450)

DSM-IV-TR Categories of Sexual Dysfunction		DSM-V Categories of Sexual Dysfunction	
Diagnosis:	Distinguishing Criteria of Diagnosis:	Diagnosis:	Distinguishing Criteria of Diagnosis:
Sexual Desire Disorders			
Hypoactive Sexual Desire Disorder	Deficient (or absent) sexual fantasies and desire for sexual activity.	Male Hypoactive Sexual Desire Disorder	Persistently or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity (deficiency is judged by the clinician).
Sexual Aversion Disorder	Extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner.		
Sexual Arousal Disorders			
Female Sexual Arousal Disorder	Inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement.	Female Sexual Interest/Arousal Disorder	Lack of, or significantly reduced, sexual interest/arousal.
Male Erectile Disorder	Inability to attain, or to maintain until completion of the sexual activity, an adequate erection.	Erectile Disorder	At least one of the following: 1) Marked difficulty in obtaining an erection during sexual activity 2) Marked difficulty in maintaining an erection until the completion of sexual activity 3) Marked decrease in erectile rigidity (in min. 75%-100% of occasions):
Orgasmic Disorders			
Female Orgasmic Disorder	Delay in, or absence of, orgasm following a normal sexual excitement phase.	Female Orgasmic Disorder	Either of the following symptoms: 1) Marked delay in, infrequency of, or absence of, orgasm 2) Markedly reduced intensity of orgasmic sensations (in min. 75%-100% of occasions):
Male Orgasmic Disorder	Delay in, or absence of, orgasm following a normal sexual excitement phase.	Delayed Ejaculation	Either of the following: 1) Marked delay in ejaculation, or 2) Marked infrequency or absence of ejaculation (in min. 75%-100% of occasions):
Premature Ejaculation	Ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it.	Premature (Early) Ejaculation	Persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approx. 1 minute following vaginal penetration and before the individual wishes it (in min. 75%-100% of occasions).

Sexual Pain Disorders			
Dyspareunia	Genital pain associated with sexual intercourse in either a male or female.	Genito-Pelvic Pain/ Penetration Disorder	Persistent or recurrent difficulties with one or more of the following: 1) Vaginal penetration during intercourse 2) Marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts 3) Marked fear or anxiety about vulvovaginal or pelcic pain in anticipation of, during, or as a result of
Vaginismus	Involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.		
Other Categories of Sexual Dysfunction			
Sexual Dysfunction Due to a General Medical Condition	Sexual dysfunction that is judged to be due exclusively to the direct physiological effects of a general medical condition.		
Substance-Induced Sexual Dysfunction	Dysfunction judged to be fully explained by the direct physiological effects of a substance (i.e. a drug of abuse, a medication, or toxin exposure).	Substance/Medication-Induced Sexual Dysfunction	Disturbance in sexual functioning that developed during or soon after substance intoxication or withdrawal, or after exposure to medication, and the disturbance is not better explained by a sexual dysfunction that is not substance/medication induced.
Sexual Dysfunction Not Otherwise Specified	Sexual dysfunctions that do not meet criteria for any specific Sexual Dysfunction.	Other Specified Sexual Dysfunction	Symptoms characteristic of a sexual dysfunction are present but do not meet the full criteria for any of the sexual disorders. Used in circumstances where the clinician specifies the reason that the presentation does not meet criteria for a specific sexual dysfunction.
		Unspecified Sexual Dysfunction	Symptoms characteristic of a sexual dysfunction are present but do not meet the full criteria for any of the sexual disorders. Used in situations in which the clinician chooses NOT to specify the reason that the presentation does not meet criteria for a specific sexual dysfunctions (includes presentations with insufficient evidence for a more specific diagnosis).

An important change between *DSM-IV-TR* and *DSM-5* is the introduction of the following *associated features:* "partner factors, relationship factors, individual vulnerability factors, cultural or religious factors, and medical factors" (American Psychiatric Association, 2013, p. 814). These newly introduced diagnostic considerations may reflect a shift to an increasingly biopsychosocial conceptualization of the sexual disorders, and increased attention to social and relational variables in the manifestation of patients'/clients' sexual problems. Equally noteworthy are the removal of *sexual aversion disorder*, due to lack of use (a finding substantiated by the questionnaire data obtained in this research study) and lack of validation, and the removal of male sexual pain disorder (Brotto, 2010a).

In the interview component of this research project, in addition to the *DSM-IV-TR* categories of male sexual dysfunction, sex addiction/hypersexuality was

examined and analysed, though this sexual problem is not included in *DSM-IV-TR*, and has not been included in *DSM-5*. The paraphilic (American Psychiatric Association, 2000, pp. 566-576) and gender identity disorders (American Psychiatric Association, 2000, pp. 576-582), however, are beyond the scope of this research project, and were not specifically examined.

6.3. Diagnostic Practices

A brief personal anecdote from my own academic background may help illustrate some of the main aspects at play in the debates about diagnostic practice. Some years ago I taught an undergraduate sociology seminar on sex and gender. With a likely exaggerated sense of my own creativity, I asked the students to briefly picture "normal sex". After allowing a moment for reflection, I inquired how many people had pictured a one-to-one encounter between a man and woman. Most of them had. I asked them what the man and woman looked like, and an overwhelming majority said they had envisioned a white, relatively youthful, height-weight proportionate couple with no visible disabilities or disfigurements. While I did not ask about the explicit details of the sexual encounter they had envisioned, I would hypothesize that most would have imagined a culturally conventional set of behaviours circumscribed under the banner of "normal" sex. This type of normative discourse about sex and sexuality is an important factor within the diagnostic arena of sex therapy (Barker, research interview, 30/03/2012; Barker, 2011a; Kleinplatz, 2012b).

Data on the themes and sub-themes relevant to diagnostic practice, apparent in the research interviews, are presented in tables 6.2 and 6.3 (in appendices M and N). An especially prominent theme within the qualitative data is the critical orientation that many research participants hold towards normative standards of sexual behaviour, with 35.3% of interviewees expressing a critical view of standardized diagnostic models of sexual dysfunction. Sub-themes within this critical viewpoint include the concern expressed by pilot tester, Parrish, that rather than describing discrete diagnoses, sexual dysfunction categories in fact describe symptom clusters, and fail to account for the aetiology of sexual problems. Additionally, a considerable proportion (23.5%) of interviewees emphasized that formal diagnoses may be labelling, or serve to stigmatize clients'/patients' sexuality. For a number of practitioners, this critical view of psychosexual pathology informs the technique of normalizing (addressed in chapter 7, section 7.2.4.), in which many

clinicians seek to question and challenge the standards of sexual 'normality' that underlie conventional psychiatric diagnosis. Consequently, within the critical approach to diagnosis that is apparent in the qualitative data, many clinicians assert that diagnostic categories have a principally heuristic value. In this regard, standardized diagnoses provide a common language to communicate with clients and colleagues, and may provide a framework that assists therapists and clients in conceptualizing sexual problems.

Standardized diagnostic frameworks, Barker asserts have a functional utility, insofar as "overall, you know what you're dealing with. Somebody's struggling to get an erection or somebody's finding that their orgasm is happening too soon for what they want to be doing" (research interview, 30/03/2012, transcript p. 3, lines 7-9). However, Barker stresses that this pragmatic usefulness has limitations, and—particularly if diagnostic categories are taken as straightforward representations of client's sexuality—can be misleading or limit the scope of the diagnosing clinician's understanding. Psychiatric diagnostic frameworks, as presented in the *Diagnostic and Statistical Manuals*, and the *International Classification of Diseases*, are

> located in a certain ideology of sex and what it should involve. Which is often part of the problem. You know? So you want to say, "actually, is it so important that you're erect? Is it so vital that you have an orgasm?" And that's where I would depart from the more conventional sex therapy, which takes that as a given, that people need: erection, penetration, orgasm, and that's what sex should involve (Barker, research interview, 30/03/2012, transcript p. 3, lines 10-15).

The sexual disorder classifications outlined in *DSM-IV-TR* and *DSM-5* are heavily informed by the sexual-response-cycle described in chapter 3 (Berry & Barker, 2014). Data obtained during the course of this study provide evidence that many diagnosticians seek to challenge the pathologizing or labelling function of conventional diagnostic practice, often by re-orienting therapeutic interventions to fit with sexual health models (Braun-Harvey, research interview, 15/11/2012; Seabloom, research interview, 13/01/2013), and by challenging and problematizing the assumptions about sexual behaviour that underlie the pathology model, and the sexual response cycle paradigm.

6.3.1. Clinicians' Critiques of Standardized Diagnostic Models

Sex therapists' concerns about diagnoses for sexual problems are evident in both the research interviews and in questionnaire responses, and appear to largely mirror a wider critique of conventional psychodiagnostic systems. The categorical model of pathology presented in *DSM-IV-TR* and *DSM-5*, in which dysfunction is considered either present or absent, with ambiguous and/or arbitrary cut-off points between health and pathology (Trull & Durrett, 2005), is a primary point of concern for many interviewees. Levine stresses that the *DSM* model is predicated on an assumption that categories of psychopathology are distinct and differentiable (Levine, research interview, 08/01/2013). However, in reality, he argues, research and clinical practice, "have converged to suggest that most diagnoses fail to evidence a clear separation from one another. This is so," he holds, "for the sexual dysfunctions as well. It is unreasonable [for instance] to say that a man with limited desire, erectile inconstancy, and an ejaculation difficulty has three sexual dysfunctions" (Levine, 2010, p. 2389). Survey data suggest that few clinicians would apply three distinct diagnostic labels to the hypothetical patient outlined by Levine.

Instead, it appears that many clinicians may be more comfortable conceiving sexual problems within a spectrum-based, dimensional model. Within this type of subjectively variable model, sexual problems are conceived as differing from healthy functioning in degree, rather than in kind (Krueger & Piasecki, 2002). Herein, sexual functioning might be conceived on a continuum, in which the clinician's interpretation of the patient's sexual problems is largely determined by the patient's individual experience and subjective goals (the prevalence of a subjective, client-led approach to goal setting is apparent in the qualitative data gathered in this study, and is discussed at length in chapter 7).

For some clinicians and researchers, diagnostic orientation involves a reflective and critical attempt to problematize the categories of sexual dysfunction, and the normative assumptions about sexual behaviour upon which they are founded. The anti-psychiatric work of Szasz is an important point of reference for this critical area. Szasz cautions that psychiatric diagnoses tend to function as descriptive categories, effectively stigmatizing certain behavioural and cognitive sets, which we label 'dysfunctions' and 'disorders', and privileging normative behaviours (Szasz, 1960, 1990). While—it is important to note—none of the clinicians surveyed cite Szasz explicitly, his concerns about pathologizing/stigmatizing patients are a

common theme within the research interviews, with interviewees highlighting the problematic function of taken-for-granted norms of sexual behaviour.

Winn, an integrative sex therapist who works primarily with LGBTQ clients, illustrates the logistical challenge of diagnosis, stating, "diagnosis creates the illusion that mental health is a thin band of experience, and tightly-reigned affective expression," and further arguing that, from a critical vantage point, "when we talk about diagnosis, just like treatment, we have to think from a multi-systemic, holistic perspective, and that can only happen by being curious, as opposed to assuming there's a fixed point of mental, physical and emotional health" (research interview, 16/01/2013, transcript p. 10, lines 37-39, p. 11, lines 22-25). An important challenge identified by many critically-oriented clinicians and researchers is the underlying ideology of mental and sexual health that informs contemporary sex therapy (Berry & Barker, forthcoming 2015; Kleinplatz, 2012a, 2012b). Respondents point out that the "thin band of experience" Winn alludes to is situated in a specific cultural context, and a mental health framework, that often privileges certain sexualities and behaviours, and sets standards of health and pathology that might not apply in other socio-cultural contexts (Graham & Hall, 2012). Consequently, a key theme in the qualitative data is the clinician's commitment to treating sexual issues in life context, expanding the focus of therapy beyond sexual issues, (a point emphasized by 20.6% of interview participants), and giving consideration to the wider social context (emphasized by 26.5% of interviewees).

6.3.2. Financial and Systemic Factors in Diagnosis

A clear theme in the qualitative data is the importance of systemic factors in diagnostic practice, and there is evidence that financial considerations influence the accepted diagnostic frameworks, the development of categories of pathology, and the application of diagnoses in clinical practice. A point of emphasis for some research participants is the amount of leverage and influence that large financial interests, like pharmaceutical companies and insurance corporations, have over the formulation of diagnostic categories. While a structural analysis of these socio-economic variables is beyond the scope of this research, it is important to note that, in the perception of some research participants, the political influence of financially-motivated corporations largely serves to compromise the integrity of clinical nosologies, a critique that is also evident in the wider literature (Tiefer, 2006, 2008; Waldinger, 2008).

One of the prominent sub-themes of the research interviews is the emphasis amongst many study participants on logistical and financial pressures for clinicians to conform to systemically mandated diagnostic protocols. Braun-Harvey summarizes this point, stating that a key element underlying the conventional diagnostic model and diagnostic practice in the clinic, is

> financial. I think it's the medical care system in the United States and the world, that you get payment for a health problem if it's a disorder, not a problem. And so there's enormous pressure for people whose livelihoods depend upon getting paid if it's [classified as] a disorder (research interview, 15/11/2012, transcript p. 9, lines 42-45).

Notably, the formal application of diagnostic classifications in clinical practice was an area of discussion where many interviewees requested to maintain anonymity. A number of interviewees indicated that in some healthcare contexts clinicians may often diagnose a psychological comorbidity—rather than a sexual disorder—in order to garner funding for an adequate number of treatment sessions, or to save clients from public embarrassment in cases when they make use of employee assistance programs (EAPs) or insurance plans. Evidence here indicates that some clients may prefer an alternative diagnosis, or even to pay out-of-pocket, over having a colleague from the human resources department, or a health program administrator process a claim for sexual health treatment (Ravella, research interview, 11/01/2013).

Interviewees suggest that some mental health practitioners, particularly those working with insurance companies and EAPs in the US, may use an anxiety disorder, or mood disorder, diagnosis to ensure that treatment will be funded. Clinically, this practice is rationalized by the routine presence of anxiety and depressive symptoms as comorbid or contributing factors in the sexual symptomatology, and by the client's apparent best interests. One highly experienced psychologist (who requested to remain anonymous on this point) states:

> because many insurance companies don't pay for sex therapy in the United States, I'm—just between us—I'm going to label somebody as having an anxiety disorder, just so the insurance company pays. And I'm probably not going to put a sexual diagnosis. So the sexual diagnoses are just something that goes on in my head when I'm seeing a couple.

Another equally senior practitioner in another jurisdiction concurs, stating, "I've always erred on the side of the client, as opposed to the government". By virtue of the widespread perception that standardized diagnostic frameworks are both

imprecise and conceptually problematic, this approach to diagnostic classification appears to be strictly a formality: rather than supplanting a more valid sexual disorder diagnosis (bearing in mind that many clinicians interviewed here question whether formal diagnosis is valid in itself) with an invalid one—such as anxiety disorder, or depressive disorder—those working within an anti-pathologizing or sexual health model are simply satisfying a systemic requirement that enables them to treat the client, subjectively and individually.

6.3.3. Identifying Symptoms, Treating Problems: an Integrative Approach to Diagnosis

As stated above, interview data strongly suggest that, within the sex therapy field, the *Diagnostic and Statistical Manual*, and the nosological system of classification for the sexual disorders that it outlines, are seen in a broadly critical purview. Daines expresses a perspective that appears to be shared by a substantial proportion of the psychotherapists interviewed, stating:

> my view on *DSM-IV*, *5* that's coming is: what it does with psychiatric, and all the conditions or the majority of the conditions, is actually cluster certain symptoms around normal distributions, rather than identify specific pathologies…therefore, they can be both helpful and unhelpful (research interview, 31/03/2013, transcript p. 4, lines 44-46, p. 5, lines 1-3).

For a majority of sex therapists, the standardized sexual disorder classifications may be of heuristic utility, providing a general language for conceptualizing sexual problems, and interacting with allied health providers. An apparently common view in the qualitative data is the view that sexual dysfunction is often symptomatic of other psychological factors (i.e. other psychopathologies)—representing a symptomatology. Consequently, as suggested in chapter 5, some research participants stress the need (with some clients) to treat other psychopathologies before treating the sexual problem.

As emphasized throughout this chapter, and further in chapter 7, another pervasive theme in research interviews for this project, is the perception that formal diagnostic categories may be potentially detrimental, insofar as they may often serve to pathologize sexual problems and integrate them within a binary system that opposes health and disease, normality and abnormality. Academically, a highly critical stance is expressed towards the conventional diagnostic framework, marked by attempts to deconstruct and challenge the discourse of pathology that is seen as

underlying the diagnostic framework for the sexual disorders (Barker, 2011a; Tiefer, 1995). Clinically, a substantial proportion of research participants express a critical view of conventional psychiatric nosology, and it appears that many clinicians may take a flexible, and functionalistic view of diagnosis, using the categories adaptively, rather than rigidly, as a means to help guide the case assessment, develop an effective general diagnostic outline, and conform to external constraints. For such practitioners, formal diagnosis may often be a distraction from the most important aspects of clinical work: understanding and treating the client's sexual problem.

6.4. 'Disorders of the Self': Psychodynamic Approaches to Assessment

One of the key contributions of psychoanalytic and psychodynamic theory is the revelation that erotic and sexual factors may underlie many of our seemingly non-sexual thoughts, feelings and behaviours (Gabbard, 2005; Gabbard, Litowitz, & Williams, 2012; Hartmann, 2009). The obverse insight—that manifest sexual problems are often symptomatic of underlying, principally non-sexual problems in the psychosocial life of the individual—is one of the key qualitative themes of this research, and appears to be a fundamental precept of sex therapy. Taken together, these insights produce a challenging clinical picture in which the sexual and non-sexual factors of a client's life overlap and interact to form a complex and distinctive clinical presentation. This component of the study evaluated clinicians' orientation towards assessment practice, and specifically on the ways in which practitioners conceptualize the role of client insight and understanding, especially of unconscious, or "deep" causal factors (Kaplan, 1979). As illustrated in the results and discussion that follow, many psychosexual therapists surveyed attest that helping the client to gain insight into, and interpret, the causal and contributing factors in the sexual problem is an essential element of psychotherapeutic change process.

6.4.1. Psychodynamic Approaches to Assessment: Qualitative and Quantitative Results

Themes and sub-themes within the qualitative data immediately relevant to assessment practice are presented in tables 6.4 and 6.5 (appendices O and P). Consistent with previously published research, data gathered in this study suggest that for many psychotherapists the goal of assessment is not merely to identify or isolate a particular disorder, problem, or symptom cluster (Daines & Perrett, 2000). Rather, the data show that for many practitioners a primary goal of assessment is to

gain insight about the client, and understanding of the concerns that have brought the client to psychotherapy, within the context of the client's life and psychosocial profile (see also tables 6.2 and 6.3, appendices M and N). For most clinicians interviewed, in everyday terms, a first principle in the assessment process, is 'getting to know' the client. Cass, who uses gestalt techniques alongside psychodynamic and cognitive behavioural methods, asserts the value of a holistic and broadly-construed approach to evaluating clients' needs at the outset of therapy; "assessment," she holds, "is not just giving a questionnaire or asking a bunch of questions. It's really trying to get a whole picture, feeling of the person" (research interview, 03/02/2013, transcript p. 13, line 33-35). Knowles corroborates this view, asserting that in-depth assessment is of particular importance, as it contributes to therapy success by:

- helping to ensure a clear outline of the clinical problem,
- situating the problem in its psychological and relational context—and thereby providing an understanding of the causal bases of the problem—and
- facilitating the early development of a therapeutic alliance between the client and healthcare provider (research interview, 30/01/2013).

Another primary theme in the data is the clinical tendency, confirmed by 35.3% of interviewees, to attend to unconscious or other psychodynamic factors in assessment. The data suggest that psychotherapists may often make use of psychodynamic interpretation in the assessment process, in examining the role of early and recent life experience and the unconscious factors that may be at play in the client's sexual difficulties (the highly prevalent tendency for clinicians to focus on early life and developmental factors in assessment and treatment is discussed at length in chapter 8).

Assessment, therefore, may often be guided by the objective of gaining insight into the interplay between conscious and unconscious elements that underlie the client's clinical concerns (de Vries, research interview, 05/02/2013; Winn, research interview, 16/01/2013). De Vries, who operates from a therapeutic model that includes a self-consciously psychodynamic element, utilizes an integrative approach to assessment that is "more loaded on the psychodynamic front, because the early days are about finding insight" (research interview, 05/02/2013, transcript p. 4, lines 19-20). This view is shared by Stock, an integrative psychosexual therapist, who asserts, "in the formulations, the background stuff is often quite psychodynamic in nature" (research interview, 17/01/2013, transcript p. 12, lines 33-34). In the assessment and case formulation stages of the therapy process, psychodynamic

insight may be emphasized as a technique that can foster insight into the aetiological pathway, and relational and developmental factors associated with the sexual problem, including the client's inner working models of relationships and persistent love schemas that inform the sexual difficulty in a relational context (an issue discussed at greater length in chapter 9). The clinician's attention to implicit factors in assessment, and the use of informal assessment are identified as sub-themes. Attending to implicit and informal factors are two means by which psychodynamic insight may be introduced in the assessment phase.

According to a number of research participants, clients may often be unaware of the links between psychological and emotional variables and sexual problems, and many interviewees describe paying close attention to unconscious and preconscious factors when assessing the client's sexual concerns and sexual history. Seabloom, who does not self-identify as a psychodynamically-oriented practitioner, presents a largely psychodynamic view of the mental content associated with sexual problems, stating:

> people tend to have things locked up inside of our minds that we don't want to look at because we're afraid of that material, or we're concerned about it…and so a way…to gain control, [and] make decisions about these things, is to open up, essentially to open up this closet in their mind, and let the light in and see what's there. And when they see what's there, then they can decide, they can see how big it is, and they can decide what they want to do with it (research interview, 13/01/2013, transcript p. 12, lines 4-11).

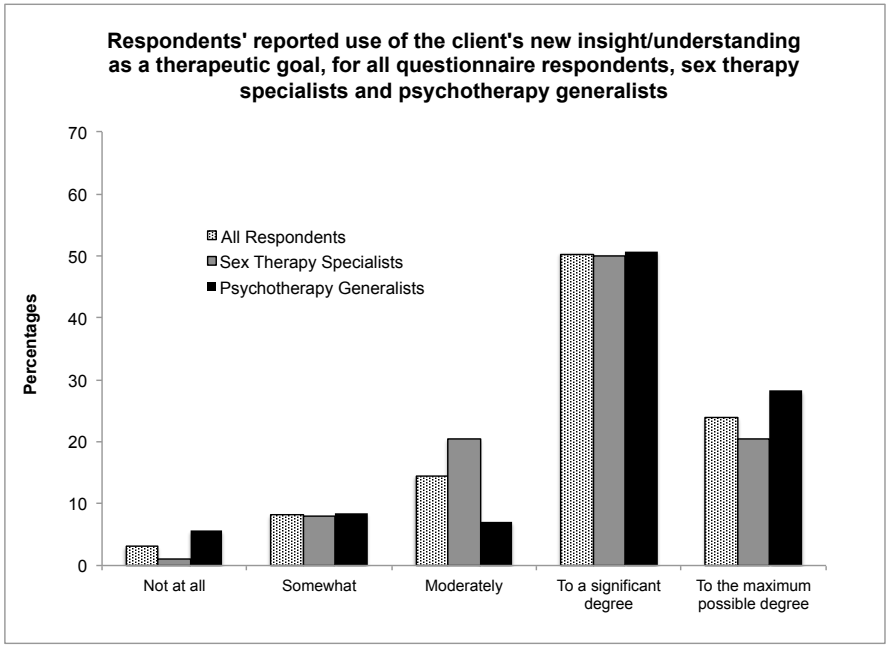
This quote illustrates the link between the insight-oriented objectives of assessment, and the importance of client insight as a clinical goal in its own right, an important issue with ramifications for psychodynamic treatment practice.

Table 6.6 and Figure 6.1 indicate the extent to which questionnaire respondents report using new insight/understanding as a therapeutic goal in their work in treating their most recent male client's sexual dysfunction.

Table 6.6
Extent to which respondents report using the client's new insight/understanding as a therapeutic goal, for all questionnaire respondents, sex therapy specialists (ST) and psychotherapy generalists (PG)

	Total Frequency	Percent (%)	Frequency (ST)	Percent (%)	Frequency (PG)	Percent (%)
Extent to which insight is used as a therapeutic goal						
Not at all	5	3.1	1	1.1	4	5.6
Somewhat	13	8.2	7	8.0	6	8.5
Moderately	23	14.5	18	20.5	5	7.0
To a significant degree	80	50.3	44	50.0	36	50.7
To the maximum possible degree	38	23.9	18	20.5	20	28.2
Total	159	100	88	100	71	100

Figure 6.1: Respondents' reported use of the client's new insight/understanding as a therapeutic goal, for all questionnaire respondents, sex therapy specialists and psychotherapy generalists



An independent samples t-test was performed to determine if there is a statistically significant difference in the degree to which sex therapy specialists (ST)(M = 3.87) and psychotherapy generalists (PG)(M = 3.81), respectively, set new insight/understanding as a clinical goal; no significant difference was found, $t(157) = 0.421$, $p = 0.674$. Three independent samples t-tests were performed to determine if there is a statistically significant difference in the degree to which sex therapist (ST) respondents and psychotherapy generalist (PG) respondents—who identify their primary treatment model as integrative, cognitive behavioural or psychodynamic—differ in the degree to which they set new insight/understanding as a clinical goal. There was no significant difference found in the degree to which ST and PG respondents who identify as integrative ($t(51) = .793$, $p = .431$), cognitive behavioural ($t(42) = .164$, $p = .870$), and psychodynamic ($t(16) = -.818$, $p = .425$) report setting new insight/understanding as a clinical goal. This indicates that new insight may be a comparably, and significantly, important treatment goal for sex therapists and psychotherapy generalists in their work with male clients' sexual difficulties, irrespective of their self-identified primary treatment modality.

6.4.2. Discussion of Results: Psychodynamic Approaches to Assessment

In itself, emphasis on insight is not inherently psychodynamic, as cognitive behavioural therapists may have a different conceptualization of insight-based

therapeutic processes; however, when linked to the importance of unconscious factors—an evident theme in the qualitative data—the focus on insight has apparent psychodynamic implications. In this respect, study participants' emphasis on the priority of gaining insight into sexual problems' psychological and social causes, alongside the importance of unconscious factors in the assessment process, indicates that integrating psychodynamic techniques into the assessment and conceptualization of sexual concerns may be of value for psychotherapists working with sexual difficulties. A psychodynamically-informed orientation to assessment and conceptualization may offer a means for understanding what Kaplan called "deep" causal factors, including the forms of psychological defence or resistance that may impede therapeutic progress (1979. P. 147; Petraglia, research interview, 31/10/2013). Additionally, for psychotherapists seeking to situate the client's symptomatic concerns within a multi-dimensional and holistic framework, psychodynamic techniques—used integratively and conjunctively alongside other psychodiagnostic methods—may offer a means for interpreting the sexual symptom within the wider context of the individual's identity. Kahr, a psychoanalytic psychotherapist with a clinical and research interest in psychodynamic approaches to sexual problems suggests that, in many cases,

> by the time people get to psychotherapists and psychoanalysts their specific symptom has already become so embedded, or is a manifestation of, a much broader sense of characterological unrest, vulnerability, fragility, loss of a sense of self, a kind of globalized depression of which loss of libido or an inability to have an erection, or to ejaculate prematurely, or to have ejaculation retardata, or whatever it might be—I think it comes as part of a larger package (research interview, 14/02/2013, transcript p. 1, lines 40-46, p. 2, line 1).

This 'larger package,' in Kahr's view, is the client's personhood, and psychological life, understood and construed broadly. Conceived in this way, rather than administering discrete diagnoses, Kahr conceives of a psychodynamic model in which sexual symptoms are situated within the wider framework of "*disorders of the self*"—the deeply-seated, and largely unconscious concerns and problems which trouble the client, and which have important sexual aspects (Kahr, research interview, 14/02/2013, transcript p. 2, line 6).

In the first instance, a psychodynamically-informed approach to assessment would seek to identify unconscious factors that might inform the sexual problem and

its course (Gabbard, 2005; Kaplan, 1987; Shevrin, Bond, Brakel, Hertel, & Williams, 1996). Such unconscious elements might be informed by prior experiences in the immediate or distant past—for instance in early life or recent events that affect the client's attachment patterns or relational style (McWilliams, 1999). Additionally, it is important to note that a number of interviewees emphasize the theory that sexual symptoms may in fact serve a functional purpose within the individual's psychosocial repertoire, or within the relational system (see also chapter 8, tables 8.1 and 8.2). The underlying theory that sexual problems may serve a psychological purpose fits with the psychodynamic view that psychopathological symptoms often offer some sort of psychological benefit, or "primary gain" to the client; for instance, in some cases sexual dysfunction may serve to reduce the client's anxiety, by making sex impossible (Katz, 1962; Weissberg & Levay, 1981). The theory that relationship factors may often make sex unconsciously conflictual or undesirable—contributing to the adaptive emergence of a sexual symptom—is a prominent theme in the data of this study. Daines and Perrett emphasize that, in this respect, "it is particularly important to identify the main defences that could underlie the sexual difficulty, or the kind of defence that the sexual problem itself represents" (Daines & Perrett, 2000: p. 119 & 121). Consequently, it may often be clinically useful to parse out some of the unconscious variables that affect the client's sexual behaviour and relationship habits. A synthesis of quantitative questionnaire data and qualitative interview data in this study highlights a number of psychodynamically-informed techniques that may be useful in the assessment of male client's sexual dysfunctions. Table 6.7 outlines some key assessment aims, and related psychodynamic assessment techniques identified in the research data.

Table 6.7
Key assessment aims and related psychodynamic techniques

Assessment objective	*Psychodynamic technique*
• Clarify unidentified psychological and psychosocial elements in the presenting problem	• Focus on unconscious factors that may have shaped the psychological or psychosocial symptom
• Identify possible aetiological roots of the sexual problem	• Discussion of early life experiences, especially with a focus on developmental processes, the emergence of relational and attachment styles, and the development of sexual and relationship schemas
	• Focus on identifying possible psychological function(s) the symptom may currently serve—or have previously served—in the individual's psychology, within the relationship, or within the wider psychosocial context
• Identify perpetuating psychological factors in the sexual problem/dysfunction	• Work to identify ongoing unconscious processes, including resistance or defence mechanisms, that may be implicated in the individual's sexual behaviours and sexual difficulties

As stated in chapter 4, evidence suggests that, in the wider psychotherapy field, clinicians may often make use of psychodynamic techniques without identifying them as such (Shedler, 2010). The data from this research project appear to confirm the often-implicit use of psychodynamic techniques in the assessment of male sexual problems with 74.2% of all questionnaire participants using insight as a clinical goal "to a significant degree" or to the "maximum possible degree", and a substantial proportion of interviewees emphasizing unconscious and other psychodynamic factors in assessment. It must be noted, however, that a substantial number of research participants do not explicitly identify these practices as 'psychodynamic', supporting the hypothesis that psychodynamic methods in assessment may often be used implicitly. Many practitioners, for instance, allude to the use of psychodynamic methods within the framework of specific psychotherapy schools—such as gestalt therapy, or existential therapy—that have a psychoanalytic or psychodynamic heritage, but that may not be identified as psychodynamic even by practitioners who adhere to them (Perls, 1973; Yalom, 1980; Yontef & Jacobs, 2008).

Data gathered in this study appear to support the hypothesis that clinical assessment—and the therapist's understanding of the client and their psychosocial concerns and behaviours—may involve a largely implicit and intuitive psychodynamic interpretation. In particular, clinicians may place strong emphasis on the client's personal and sexual history, especially early life factors and how they relate dynamically to the client's present psychosocial state and identity. It appears that many clinicians may make significant use of psychodynamic interpretation, but assessment of the unconscious and dynamic factors of the patient's psychosocial, and sexual, concerns, during assessment and throughout the therapy process may often be implicit. For many practitioners, dynamic interpretation may be an informal and intuitive dimension of psychotherapy process, used as needed, first to gain insight, and then to help in the selection or utilization of particular therapy techniques.

6.5.1. Informal Assessment Practices

A number of interviewees point to the very earliest contact with a client as the beginning of the assessment process (Milrod, research interview, 11/10/2012; Ravella, research interview, 11/01/2013). Assessment, some assert, begins informally and involves attending to subtle factors in correspondence, including the client's word choice and syntax, inflection, disposition and demeanour, choice of

specific topics either directly related or tangential to the presenting concern, and omission of possibly relevant details, in the initial contact and first meetings. This informal assessment process, emphasized by 20.6% of interviewees, involves a high level of attention to subtle, tacit, and implicit elements in the client-therapist interaction. Interview data indicate that many clients may have obvious difficulty in conceptualizing their sexual problem or clinical goals; "a lot of the times when you ask people what they hope to gain," Ravella states, "they don't know what to say. They're just telling you that they're in some distress" (research interview, 11/01/2013, transcript p. 5, lines 30-32). This ambiguity may reflect a number of factors including:

- deficits in the client's ability to mentalize or understand the clinical problem, including both its symptomatic presentation, and its possible contributing factors,
- discomfort expressing the concern, despite a relatively high level of understanding about the problem,
- a low level of vocabulary about the problem, or
- limited understanding about the therapy process, and what can reasonably be expected.

Consequently, for many practitioners, it appears that physical and nonverbal communication are points of focus in assessing the client's perspective on the treatment process; it is stressed that attention to these cues may give insight into the client's attitude towards the psychotherapeutic change process—an important predictor of psychotherapy outcome (Asay & Lambert, 1999). To maximize the accuracy of informal impressions, it may often be necessary for the clinician to take close note of limited behavioural cues, and the client's choices about what information to disclose, and how to frame this information. Ravella outlines a specific assessment strategy that instantiates this approach; "when I'd [first] see an individual," she states,

> I would write down the very first words they said when they walked into my office, even if it was something like: 'wow, that's a pretty plant'. I mean, as crazy as that sounds, 99% of the time their very first comment had a lot to do with what we were going to be doing. Something as off the wall as "wow, that's a nice plant" or something like that (research interview, 11/01/2013, transcript p.5, lines 25-29).

In addition to attending closely to information that may at first appear trivial or tangential to the clinical issue, informal assessment may also entail monitoring for relevant information that the client may omit. In particular, missing information about sexual history, current relationship status, and affective dimensions of the clinical problem may indicate the significance of these very factors. From a psychodynamic vantage point, avoidance of specific issues may also reflect a resistance to the treatment process, though this may be best assessed as treatment progresses and more information is gathered (Daines & Perrett, 2000).

The data in this study appear to support the hypothesis that a psychodynamically-informed approach to informal assessment can offer information on: a variety of aspects of the client's sexual problem, the wider relationship context in which the sexual problem persists, and the client's orientation to treatment. "From a psychodynamic point of view," one interviewee states,

> I'm trying to pick up what's going on beneath the surface, looking at: what sort of patterns of connection between the past and present there might be, what sort of transferences, whether this person is coming in expecting me to solve everything, or whether they've been places before and therefore they've become very skeptical about anybody helping, how much they might see me as an authority figure (Daines, research interview, 31/03/2013, transcript p. 7, lines 20-26).

With respect to aspects of the client's sexual relationship that may be of relevance for therapy, he proceeds to state,

> I will be looking at what the dynamics might be in their relationship. Particularly what projective identifications[28] might be going on. Because often the situation is that a lot of what's attracted people at the beginning of their relationship has now become a source of frustration…So, I guess one of the things I do with students in the psychodynamic input, is to get them to be aware of the non-verbal information that's coming during an assessment that can be looked at psychodynamically (Daines, research interview, 31/03/2013, transcript p. 7, lines 26-35).

Daines also stresses that informal assessment of non-verbal information may be supported by attending to counter-transferential responses to the client. Counter-

[28] *Projective identification* is a psychodynamic ego defence mechanism, in which parts of the self are unconsciously experienced as parts of the other person. This preserves the ego by separating (projecting) unacceptable psychological elements from the self, but maintaining a connection (identification) with these elements.

transference is here understood as encompassing the therapist's conscious and unconscious thoughts and feelings towards the patient (Kernberg, 1965; Sandler, Holder, & Dare, 1970). Information can be gleaned from the therapist's counter-transferential feelings by an evaluation that first inquires: how do I feel towards the client? and secondarily, "what does that mean in terms of what's going on?" (Daines, research interview, 31/03/2013, transcript p. 8, lines 2-3). This psychodynamic technique can be employed both in the early stages of assessment and ongoingly throughout the assessment process.

Published research suggests that assessment is an ongoing process that "continues long after the intake" as the links between sexual and non-sexual elements of the individual's identity, or couple relationship, become clearer (Meana, 2010, p. 103). The progression of the therapy, they stress, can be expected to bring new issues to light, especially by virtue of the sensitive nature of sexual and relationship issues, and the high level of intimate disclosure that is involved in psychosexual therapy. A number of interview participants also highlight the conceptualization of assessment as a persistent process throughout the course of therapy. As such, published research supports the data collected here, which indicate that psychosexual therapists may often view informal assessment as a technique that is used continuously throughout the therapy process. This ongoing assessment process facilitates adjustment of the treatment plan, and use of a shifting formulation (a concept discussed in detail in chapter 7).

6.5.2. Formal Assessment Procedures

Levine underscores the need for explicit questioning and formal assessment procedures, while illustrating the importance of context, environment, and empathetic disposition during the intake. "Therapy," he states,

> begins with an evaluation that has a respectful, comfortable environment that allows the patient to talk and tell his story. And many patients can't tell their story without being prompted by intelligent questions that illuminate the multiple dimensions of the problem (Levine, research interview, 08/01/2013, transcript p. 4, lines 23-26).

A biopsychosocial approach to assessment necessitates that the clinician account for the multi-dimensionality of the problem, as Levine states, gaining a broad picture of the client, their relationship status, and relevant aspects of their history. A sexual history taking that includes attention to medical as well as psychosocial factors, is

viewed as a best practice in the assessment process, and a considerable number of interview participants (35.9%) emphasize the use of a comprehensive sexual history during the assessment stage (Berry & Berry, 2014; Perelman, 2005a; Perelman et al., 2004). Evidence suggests that medical information gathered in a comprehensive sexual history-taking is used both as a basis for referral, and to contextualize the psychosocial aspects of the patient's clinical presentation, which are the focus for psychosexual therapists (Barker, research interview, 30/03/2012; Braun-Harvey, research interview, 15/11/2012).

However, the degree to which sex therapy specialists and psychotherapy generalists use formal instruments—including questionnaires—to assess clients and track the progress of therapy, appears limited. Table 6.8 indicates the extent to which respondents report using patient questionnaires in assessing patient condition and/or progress with their most recent male client.

Table 6.8
Extent to which respondents report using patient/client questionnaires in assessing patient/client condition and/or progress with most recent patient/client, for all questionnaire respondents, sex therapy specialists (ST) and psychotherapy generalists (PG)

	Total Frequency	Percent (%)	Frequency (ST)	Percent (%)	Frequency (PG)	Percent (%)
Extent to which respondents use questionnaires						
Not at all	93	58.5	48	54.5	45	63.4
Somewhat	25	15.7	11	12.5	14	19.7
Moderately	18	11.3	13	14.8	5	7.0
To a significant degree	17	10.7	10	11.4	7	9.9
To the maximum possible degree	6	3.8	6	6.8	0	0.0
Total	*159*	*100*	*88*	*100*	*71*	*100*

An independent samples t-test was performed to determine if there is a statistically significant difference in the degree to which sex therapist (ST) ($M = 2.03$) respondents and psychotherapy generalist (PG) ($M = 1.63$) respondents report using questionnaires to assess/measure the client's condition or progress, with their most recent male client treated for sexual dysfunction. A statistically significant difference was found, with ST respondents reporting more use of questionnaires, $t(157) = 2.104$, $p = .037$.

Overall, however, use of questionnaires in assessing client/patient progress appears to be uncommon amongst both groups, with a majority of all questionnaire respondents (58.5%) reporting that they did not use questionnaires at all with their most recent client. Likewise a small majority of sex therapy specialists (54.5%) reported that they did not use questionnaires with their most recent male client. Additionally, a number of interviewees report using questionnaires variably, or occasionally, rather than as a matter of consistent procedure. In fact, both the quantitative and qualitative data in this study support the conclusion that

questionnaires are not commonly utilized, as 23.5% of interviewees report making little or no use of questionnaires in the treatment of male sexual problems.

In favour of questionnaires and psychometric instruments, interview data suggest that open-ended and broad questions are prevalent, with 26.5% of interviewees reporting the use of this method in the early assessment process. A number of research participants report that they begin with open-ended questions, such as: "how can I be of help?" or "can you tell me what the issue is?" (Alman, research interview, 09/01/2013; Milrod, research interview, 11/10/2012; Seavey, research interview, 01/02/2013). Perring suggests that this type of open-ended questioning may be a distinguishing factor of psychotherapeutic (as opposed to medical) sexual healthcare, and identifies it as a "non-directive" approach which is focused on gaining a complete, contextual understanding of the sexual problem, and fostering the conditions for a strong therapeutic alliance (research interview, 14/12/2012, transcript p. 5, line 36). Additionally, some interviewees (5.9%) indicate that they use subjective rating scales—for instance, approximate/estimative 1-10—in asking the client to rate the severity of symptoms (see tables 7.1 and 7.2, in appendices Q and R).

The importance of involving the partner in the assessment to at least some degree is a prominent theme in the data collected from both interviews and questionnaires, a finding consistent with the data presented in chapter 5, above. As stated, a number of therapists indicate the value of alternating between individual sessions and couple sessions in the assessment phase. Interview data indicate that a four-session assessment model is relatively common for psychosexual therapists working with both members of a couple, and McCarthy recommends a "four session assessment model of: seeing the couple together for the first session, seeing them each on their own to do a psychological, relational, sexual history, and then the couple feedback session" in which the case formulation is presented and couple-based subjective goals are negotiated (research interview, 17/01/2013, transcript p. 1, lines 32-35).

6.6. Assessment of Predisposing, Precipitating and Perpetuating Factors

A focal point in the assessment of sexual problems, which is particularly salient in the greater body of published research, is how biopsychosocial factors

predispose, precipitate, and maintain/perpetuate sexual difficulties.[29] The interviews conducted in this research project offer evidence that many sex therapy specialists focus on understanding the aetiology of the client's sexual problem, and on helping the client to gain such an understanding, as a basis for effective treatment. According to Masters, Johnson and Kolodny:

> behaviorists generally believe that a precise understanding of causation is less important in treating a sexual dysfunction than recognizing the conditions that *maintain* the difficulty, since these are the ones that need to be changed (Masters, Johnson & Kolodny, 1982: 383).

In practice, however, a high proportion of the sex therapists interviewed appear to take an integrative approach to assessment, focusing on predisposing, precipitating and maintaining factors with 26.5% of interviewees explicitly indicating the use of the predisposing-precipitating-perpetuating factors model, and 11.8% indicating a psychodynamically-oriented use of this model, characterized by emphasis on the unconscious influence of early life factors over current sexual functioning within a pred.-prec.-perp. factors model, or by explicit attention to the role of psychodynamic processes (i.e. conflict, defence mechanisms, etc.) within the model.

This study sought to evaluate the hypothesis that attention to formative experiences and to past experiences, with a developmental focus, would be common techniques for psychosexual therapists. To test this hypothesis, questionnaire respondents were asked:

1) In the most recent case of male sexual dysfunction you treated, to what extent did you examine the patient's formative (earlier life) experiences as influencing current relationships/sexual functioning?
2) In the most recent case of male sexual dysfunction you treated, to what extent did you discuss the patient's past experiences (especially with a developmental focus)?

Responses were measured on a five point Likert scale, ranging from "not at all" to "to the maximum possible degree". In the following sections these questionnaire results are reported and discussed, with attention to how they accord with the

[29] Within this assessment model, the work of sex therapists and psychotherapists often focuses on the psychosocial aspects of sexual dysfunction, though it is important to note that biological components, including endocrine factors, neurologically mediated factors, genetic heritability factors, and the influence of comorbid pathology, are important to consider in the diagnosis and management of clients' presenting problems. This complex interplay of factors underscores the importance of integrative multidisciplinary treatment protocols, and referral networks, as discussed in chapter 5 above (Althof & Rosen, 2011; Berry & Berry, 2014; Simopoulos & Trinidad, 2013).

predisposing, precipitating, and perpetuating factors model, which, interview data suggest, is prevalently used by psychosexual therapists surveyed.

6.6.1. Clinicians' Focus on Formative and Past Experiences: Questionnaire Results

Table 6.9 indicates the extent to which survey participants reported focusing on their patient/client's formative experience, and past experiences (especially with a developmental focus) in clinical dialogue with their most recent male client presenting for the treatment of sexual dysfunction.

Table 6.9
Extent to which respondents report focusing on patient's/client's formative experiences, and past experiences (esp. with a developmental focus) with most recent patient/client, for all questionnaire respondents, sex therapy specialists (ST) and psychotherapy generalists (PG)

	Total Frequency	Percent (%)	Frequency (ST)	Percent (%)	Frequency (PG)	Percent (%)
Extent of focus on formative experiences						
Not at all	3	1.9	2	2.3	1	1.4
Somewhat	11	6.9	9	10.2	2	2.8
Moderately	33	20.8	18	20.5	15	21.1
To a significant degree	82	51.6	45	51.1	37	52.1
To the maximum possible degree	30	18.9	14	15.9	16	22.5
Total	*159*	*100*	*88*	*100*	*71*	*100*
Extent of focus on past experiences (dev. focus)						
Not at all	3	1.9	3	3.4	0	0.0
Somewhat	18	11.3	15	17.0	3	4.2
Moderately	45	28.3	23	26.1	22	31.0
To a significant degree	79	49.7	40	45.5	39	54.9
To the maximum possible degree	14	8.8	7	8.0	7	9.9
Total	*159*	*100*	*88*	*100*	*71*	*100*

An independent samples t-test was performed to determine if there is a statistically significant difference in the extent to which sex therapist (ST) (M = 3.38) respondents and psychotherapy generalist (PG) (M = 3.70) respondents report discussing the client/patient's past experiences, especially with a developmental focus; a statistically significant difference was found, with psychotherapy generalists reporting greater use of this technique, $t(157) = -2.386$, $p = .018$. An independent samples t-test was performed to determine if there is a statistically significant difference in the extent to which sex therapist (ST) (M = 3.68) respondents and psychotherapy generalist (PG) (M = 3.92) respondents report examining the client/patient's formative (earlier life) experiences as influencing current relationships/sexual functioning; no statistically significant difference was found between these two groups, $t(157) = -1.644$, $p = 0.102$.

For the entire participant sample, and for both respondent groups, a majority of respondents focus on formative experiences and past experiences "to a significant degree" or "to the maximum possible degree", suggesting that a high level of focus on formative and past (developmental) experience is prevalent for both groups.

6.6.2. Clinicians' Focus on Formative and Past Experiences: Discussion of Results

Interview data on the role of early and formative experiences as a focus in treatment appear to support the questionnaire findings, indicating that a substantial proportion of sex therapy specialists surveyed consider early life and developmental factors a crucial area for clinical discussion. As stated above, the role of early life and developmental factors is discussed at greater length in chapter 8, which evaluates clinicians' understandings of the aetiology of sexual problems. Here, three key points must be emphasized:

1) gaining insight into the causal factors underlying the client's sexual problems is widely considered a necessary element of the therapeutic change process (a point discussed at greater length in chapter 7),
2) a majority of research participants, in both the questionnaire and interview components of the study emphasize the client's early life, and the influence of family of origin and parents, as key contributors to the client's current sexuality and sexual functioning, and
3) a high level of emphasis is placed—both explicitly and implicitly—on the unconscious role that formative, developmental experiences have over the patient's sexuality and sexual functioning.

Consequently, the quantitative and qualitative research data suggest that focusing on formative and past experiences in the client's life (especially early life and family of origin) is common practice when treating male sexual dysfunction. The data also indicate that this focus may be linked to both the objective of instilling insight into the aetiological origins of the sexual dysfunction, and to the assumption that unconscious variables may be implicated in this causal process. The primary objective of this exploration—which is often carried out using the pred.-prec.-perp. factors assessment model—appears to be endowing the client with insight into the ways in which early life, formative and developmental experiences have shaped his current sexual and relational identity, and problems in these domains.

6.6.3. Clinicians' Use of the Predisposing, Precipitating and Perpetuating Factors Assessment Model

The predisposing-precipitating and perpetuating factors model of formal assessment in psychosexual therapy is attributed to the work of Hawton (1982, 1985), and appears to have become a commonplace framework in sex therapy

training programmes and in sex therapy practice in the UK and North America (Wincze, 2009; Wincze & Carey, 2001). In the UK, the predisposing-precipitating-perpetuating factors model is commonly taught at leading training institutes, including Relate (http://www.relate.org.uk/), and the Tavistock Centre for Couple Relationships (http://www.tccr.org.uk/)(Green & Seymour, 2009). This model prescribes categorizing the trajectory of the sexual dysfunction according to:

- predisposing factors—vulnerability factors, attributable to prior life experiences, including recent or early life experiences, which render the client susceptible to a particular sexual problem.
- precipitating factors—recent or ongoing aspects of the client's life, either within the context of sexual behaviour (as in the case of an adverse or distressing sexual encounter or event), or outside of the sexual setting (as in the case of a stressful event in professional life, for instance), that catalyze a sexual problem.
- perpetuating factors—ongoing elements in the client's life that serve to maintain the problem. These may include relationship dynamics with a partner, or psychological reinforcement of the sexual problem (through the development of thoughts, emotions, or behavioural schemas that impede the desired sexual functioning) (Hawton, 1982, 1985; Wincze & Carey, 2001).

This framework mandates that the clinician assess the patient's sexual history, in order to identify predisposing and precipitating factors, and the patient's current sexual and extra-sexual life circumstances, in order to identify the factors that serve to perpetuate the sexual problem. It is important to note, however, that, "often there is not a clear distinction between predisposing and precipitating and precipitating and maintaining factors" (Althof et al., 2005, p. 794), and the predisposing-precipitating-maintaining factor model may be used as a means for classifying highly interrelated factors in an assessment formulation.

Although, as Daines emphasizes, Hawton's model was initially offered as a cognitive behavioural framework, it has widely been taken up in sex therapy as a "basic generalist approach" (research interview, 31/03/2013, transcript p. 5, line 34), and collected data indicate that psychosexual therapists regularly use the predisposing-precipitating-perpetuating model within a modally-integrative framework that includes both psychodynamic and cognitive treatment methods, and other methodologies. Here, evidence from this study, and previously published research, suggest that evaluation of predisposing, precipitating and perpetuating

factors may be useful to therapists working within a wide range of psychotherapeutic schools (Daines & Perrett, 2000).

In addition to the multi-modal utility of the predisposing-precipitating-perpetuating factors model, research interviews clearly indicate that this model may be a useful tool in assessing and conceptualizing early-life variables, with a view to integrating CBT and psychodynamic approaches, and attachment-theory-based treatment. The predisposing-precipitating-perpetuating factors model may, for instance, be useful in structuring both psychodynamic and cognitive behavioural interpretations of formative and developmental factors, including examination of attachment styles and relationship schemas, focal areas identified in the research interviews (discussed further in chapter 8).

As Daines notes, psychodynamic practitioners utilizing the model may often take an integrative view, which maintains a focus on the vital link between early predisposing factors, and present sexual experience. This indicates a likely point of consensus between psychodynamically-oriented practitioners and their non-psychodynamic counterparts, as it appears that, for many of the sex therapy specialists interviewed (irrespective of their primary clinical methodology), early life experiences are seen as important insofar as they can be linked to current problems in sexual functioning or relationship (Cass, research interview, 03/02/2013; Seymour, research interview, 04/07/2013; Stock, research interview, 17/01/2013).

6.6.4. Psychodynamic Application of the Predisposing, Precipitating and Perpetuating Factors Assessment Model

Collected data suggest that the predisposing-precipitating-perpetuating model may be useful as a template for understanding and interpreting unconscious processes, including the unconscious influence of early life events and parental relationships, psychological defences, and unconscious resistance to the psychotherapeutic process (O'Connor, research interview, 07/02/2013). More specifically, a psychodynamic theory that may be especially useful in the diagnosis and assessment of psychosocial factors in sexual problems, and which may be integrated with the predisposing-precipitating-perpetuating factors model is: the concept of non-conscious, or in psychoanalytic terms *preconscious*, and *unconscious* variables in sexual functioning.[30]

[30] In Freudian psychoanalytic theory, the term "unconscious" is used as both a noun and adjective, to describe both a region of the mind, and to describe the quality of certain psychological content. In the

Psychodynamic theory is predicated on the belief that prior experiences, including early life experiences, affect us on a largely unconscious level (Bateman et al., 2010; Jacobs, 2010). Data from this survey suggest that many sex therapy specialists, and psychotherapy generalists working in the treatment of male sexual dysfunction, hold the view that some aspects of the underlying causal processes behind sexual dysfunction operate at unconscious and/or preconscious levels. Additionally, as indicated in table 6.6 and figure 6.1 above, gaining insight into the causal processes underlying the sexual problem, is widely seen as a crucial therapeutic goal. Consequently, attention to early and recent life experiences, which focuses on the role of unconscious and preconscious factors, may be an important aspect of assessment in the treatment of male sexual problems. In the formal assessment process, psychotherapists may often examine the ways in which prior earlier experiences unconsciously or preconsciously predispose or precipitate the client's sexual problems, and the ways in which perpetuating factors may work at a preconscious or unconscious level to maintain the sexual dysfunction. Interview data suggest that entrenched unconscious patterns of behaviour, cognition and affect may contribute to current and ongoing sexual concerns, for many clients (Petraglia, 2013; Stock, 2013; Daines, 2013; Seymour, 2013; De Vries, 2013; O'Connor, 2013; Kahr, 2013). Elicitation of a thorough sexual history is widely recommended as standard assessment practice, and may offer insight on the role of unconscious or unidentified aspects that contribute (either as predisposing, precipitating, or perpetuating factors) to the sexual difficulty.

6.7. Use of Sexual History Taking

Taking a thorough sexual history is accepted as an essential process of care standard in biopsychosocial sexual healthcare (Berry & Berry, 2014; Montorsi, Adaikan, et al., 2010; Montorsi, Basson, et al., 2010), and a core practice in psychosexual therapy, with 35.5% of interviewees emphasizing the importance of taking a thorough sexual history during client/patient assessment. In addition to

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latter regard, the concept of the unconscious is used to "designate not only latent ideas in general, but especially ideas with a certain dynamic character, ideas keeping apart from consciousness in spite of their intensity and activity" (Freud, 1958, p. 262). In a general sense, it may be said that certain elements are confined, or repressed, to the unconscious as they are unacceptably painful, or distressing. By contrast, the preconscious is conceived as a sort of 'ante-chamber' between the conscious and the unconscious (Freud, 1961d). Rather than being repressed, material in the preconscious is consciously suppressed and, though it is temporarily forgotten, it may readily be recalled.

providing insight into the general course of the patient's sexual concerns, Perelman writes,

> the history may provide insight into the deeper causes of the patient's dysfunction and may reveal cultural and/or neurotic origins of the problem. Factors from the past may include losses and/or a variety of traumas, including negative past sexual relationships and negative past interpersonal relationships. Other factors, such as cultural and religious restrictions, may also be significant (2006b, p. 115).

Consequently, alongside a general evaluation of the client's biographical background and past life experiences, process of care standards advise that clinicians specifically assess: general personal and family history, personal and family history of physical illness, personal and family history of mental illness, history of sexual experiences, family of origin experiences, and co-morbid factors including anxiety and depression (Lue, Basson, et al., 2004; Montorsi, Adaikan, et al., 2010; Montorsi, Basson, et al., 2010).

As stated, the qualitative data confirm clinicians' common tendency to focus on psychosocial family of origin factors within the sexual history-taking. Cass advocates evaluating, "what specific key issues have emerged from childhood that might be very sensitive points for them? For example, they might have had a difficult relationship with the father which now affects the way they choose partners" (research interview, 03/02/2013, transcript p. 15, lines 5-8). In a more general sense, Dunn suggests,

> you have to have had some good experiences with somebody who loved you and took care of you, to help you be able to be emotionally intimate and physically intimate with another person. I mean, there are some automatic responders, for sure, but most of us need to have a degree of trust in order to be intimate with another person (research interview, 29/01/2013, transcript p. 6, lines 37-41).

An important factor in family of origin experience is role modelling of sexual and relational styles, which is seen as contributing significantly to the development of attachment styles, love schemas, and inner working models of sexual relationships (Gutteridge, research interview, 23/01/2013; see also chapter 8, tables 8.1 and 8.2).

Additionally, research participants stress that taking a comprehensive sexual history can offer insight into the circumstantial, and deeper psychodynamic factors,

in the aetiology of the presenting sexual problems. "From a psychodynamic point of view, in terms of background" de Vries states,

> you cannot divorce the present from the past. So, going over the background, trying to find out why somebody ticks and how they tick, but also what the defences are that they bring into play [is essential]" (research interview, 05/02/2013, transcript p. 3, lines 35-38).

Thus, interview data indicated that the client's sexual background and prior experiences are of clear interest, with interviewees indicating the importance of early and first sexual experiences, as well as any experience of trauma.

The high level of focus on family of origin and early life factors in sex therapy, suggested by the collected data, may itself provide an avenue for evaluating both the conscious and unconscious effects that early experiences may have on the development of the individual's sexual schemas and attachment style—an element discussed further in chapter 9. This perspective reflects an apparently common tendency, evident in both questionnaire and interview data, for psychotherapists to focus on sexual history, and especially early life experience, as it pertains to the client's attachment style and relationship schemas.

A concept from attachment theory, that may help clarify the manner in which many sex therapists conceive of the client's sexual and relationship style is the notion of an internal working model—a dynamic mental model, which uses the past as a key referent for determining how the world may work (Fisher & Crandell, 1997; Slade, 2008). Rather than a 'map' (which implies a static and uni-dimensional representation of our world), the internal working model is seen as an evolving working representation of the environment, and the individual's role therein, subject to change through experience (Bowlby, 1969, p. 80). This conception of "internal working models" offers a framework for interpreting the development of *love schemas*—a conceptual system within attachment-based psychosexual therapy, which posits that romantic and sexual models of relationship are heavily linked to attachment experiences in infancy and childhood (Choo, Levine, & Hatfield, 1996; Hatfield & Rapson, 2010). Formative early life experiences—including attachment experiences—inform the early development of internal working models of relationship, and the ongoing development and revision of relational love schemas. In this respect, problems in the client's sexual and intimate life may often have roots in early life experiences, necessitating the importance of comprehensive sexual

history taking, and the therapeutic value of gaining insight into early life formative and developmental experiences.

Overall, both published research and data collected in this study indicate that, in addition to providing information on possible biological variables and current/immediate psychosocial antecedents, a comprehensive sexual history provides a basis for understanding the client's sexual problem within a psychobiographical context that provides insight on the individual's attachment style, and relational schemas, and how these factors may influence the sexual problem as well as the intended treatment course.

6.8. Identifying Underlying Factors: What is the Actual Problem?

Data show that a key priority for psychosexual therapists is to gain an understanding of the way individual clients conceive of their sexual problems. Ravella suggests, for instance, that while some men may complain of erectile difficulties—often using a mechanical, or anatomical language—clinical assessment routinely shows an underlying desire or relationship problem. Desire difficulties, Ravella holds, may be a common concern for male clients, though she suggests they often "wouldn't call it that. They would talk about, you know: 'what can I do to improve my erection?' But when you talk about what the problem was, it wasn't something that Viagra or Cialis was going to fix—it was low desire" (research interview, 11/01/2013, transcript p. 2, lines 26-28). Published research suggests that the ways in which clients conceptualize their sexual difficulties depend upon a range of factors, which include cultural conceptualizations of sexuality, alongside psychological and cognitive variables (Graham & Hall, 2012; Hatfield & Rapson, 2010).

Psychologically, some clients may have a limited ability to conceptualize or mentalize the problem, either personally or as a relationship factor. Qualitative data from this study suggest that a priority is placed on psychoeducation as a primary clinical intervention, with 55.9% of interviewees emphasizing the use of psychoeducation (see table 5.6 and 5.7 in appendices K and L). The widely noted importance of psychoeducation is linked with an apparent belief amongst many sex therapy specialists that limitations in clients' informational and conceptual understanding of the role of sexuality—both within the context of the client's own mental processes and within the client's interpersonal relationships—are amongst the primary determinants of sexual problems (see tables 8.1 and 8.2, in appendices U and

V). As Fonagy suggests, in many cases, these limitations may reflect a deficit in the client's capacity to mentalize the sexual relationship—specifically, to gain and maintain awareness (both explicit and implicit) of cognitive and affective states in self-and-other, and awareness of intentionality (Fonagy, 2008b).[31]

An important variable, which introduces a challenge to assessing the sexual problem, and understanding the way the client conceives of the problem in a relational context, is the complex interaction between sexual behaviour and other relationship factors. A prominent theme in the research interviews, alluded to in section 5.5.2., is the conception that relationship problems may manifest as, or contribute to, sexual problems and, conversely, that sexual problems may contribute to or exacerbate relationship problems (Daines & Perrett, 2000, p. 35-36). A considerable proportion (38.2%) of interviewees indicated that non-sexual relational problems may present as, or intensify, sexual problems (tables 5.6 and 5.7, appendices K and L). "Often when you have a presented sexual problem," Plaut states, "it turns out to be more of a relationship issue than a sexual one, so it's very important to look at the broad scope of things" (research interview, 17/01/2013, transcript p. 1, lines 32-34). Resnick echoes this position, stating that it is "often the case" that "the sexual difficulty is really a reflection of the emotional relationship" (research interview, 04/11/2012, transcript p. 4, lines 14-15). Consequently, Plaut elaborates,

> you cannot take a presenting complaint at face value…a person may come in and say that: 'my partner is not interested in sex with me anymore' or 'I'm not interested in sex anymore'. And so it looks at its face like a desire issue. But when you start exploring where it began you may see, and it's often that you see, that it may have started with pain on intercourse, or it may have started with erection problems and anxiety about not having erections, or not being able to perform, or not being able to have an orgasm in intercourse. What happens is the two people drift away from each other. And so you end up with what looks like a lack of interest in sex, it is, but the actual sexual symptom—the original sexual symptom—is something very different (research interview, 17/01/2013, transcript p. 4, lines 32-42).

[31] The role of mentalization as a factor in sexual problems is addressed at greater length in chapters 8 and 9 (see especially sections 8.7. and 9.2.5.).

It may be argued that this complex clinical scenario underscores the need for rigorous and comprehensive screening, focused examination of the relationship context, and attention to unconscious factors, in the assessment process.

For sexual therapists working within the sexual health and non-pathologizing model, in particular, there appears to be a significant focus on the phenomenology and specific manifestation of the individual client's sexual concern. In fact, as Barker and Kleinplatz stress, sexual dysfunction, considered in a relationship context may often be an adaptive, and potentially unconscious, response to psychosocial factors, including aversion to a partner, or other psychological and emotional factors, such as bereavement, etc., which impact on sexual functioning (Barker, 2011a; Kleinplatz, 2012a, 2012b). From the evidence, it appears important to stress that psychosocial factors not immediately associated with sex may have a causal or contributory role in sexual problems, implying that there may often be an unconscious or preconscious link between non-sexual variables and sexual ones. Evidence suggests that one of the clinician's primary assessment goals is to gain an understanding—and foster client insight—into the individual and relationship factors and processes that are implicated in the sexual problem, many of which may be outside the scope of the client's reflective awareness, and which may implicate the client's mentalizing capacity, attachment style, and relationship schemas.

6.9. Diagnostic Practice: Summary of Findings

As the data presented in chapter 6 illustrate, sexual therapy practitioners hold widely divergent views on the psychiatric diagnostic models of sexual dysfunction. Whether the sexual disorder diagnoses represent discrete categories of psychopathology or an overly restrictive system that serves to enforce normative standards of sexual behaviour is a matter open to considerable debate. The qualitative data from this study, however, suggest that a critical perspective may be prevalent. Some practitioners, the data suggest, may utilize diagnostic categories on a pragmatic basis, primarily to fulfil institutional requirements or in communicating with allied health providers. Additionally, the role of financial institutions—including insurance companies—is seen as influencing the diagnostic landscape, and there is evidence that some practitioners may use diagnostic categories flexibly and strategically, to garner the funding necessary for patient treatment.

This chapter also described the data on a number of psychodynamically-informed principles that may be of particular relevance in the assessment of clients'

sexual difficulties. In particular, research participants appear to place a high level of emphasis on the importance of insight—both client insight and clinician insight—as an element of assessment and diagnosis. In this regard, data suggest that a considerable proportion of interviewees may view insight as both an assessment objective and as a clinical goal. The focus on insight appears to implicate attention to unconscious processes. A high level of focus on the role of past and early life experiences, and evaluating the client's sexual history with a developmental focus, is also apparent in the data. Here, it appears, clinicians may work to understand the sexual problem with reference to the client's sexual history, and in light of unconscious factors in the individual's subjective development across time. As the next chapter will illustrate, the data also show that clinicians' tendency to focus on the client's subjective identity also extends to goal setting, case formulation, and working with diversity.

CHAPTER 7. ESTABLISHING CLINICAL GOALS AND DEVELOPING A CASE FORMULATION

7.1. Introduction: Case Formulation, Goal Setting and Subjective Aims for Unique Clients

An uncritical reading of the *DSM* diagnostic categories may lead to the conclusion that men's sexual objectives are predictable. The implicit binary categories of function-and-dysfunction in *DSM-IV-TR* suggest a de facto set of goals: penile rigidity sufficient for penetrative intercourse, timely ejaculatory responsiveness, and a strong and consistent desire for sex. One of the principal findings of this research, however, is that in a clinical setting the goals negotiated for sex therapy with male clients often do not correlate directly with the *DSM* model of sexual functioning or with the traditional sexual-response cycle model. As discussed in chapter 6, many of the clinicians surveyed take a critical view of the diagnostic model of sexuality, arguing that it imposes a rigid and narrow perspective on sexual response and behaviour, which disregards what is subjectively desirable or realistic for the client.

In addition to understanding how sex therapists conceptualize and assess sexual problems, it is important to understand how clinicians work with clients to develop case formulations and set clinical objectives. This chapter outlines survey data on clinical practices in goal setting, including clinicians' emphasis on setting subjective and realistic goals, and on the use of a pleasure- and desire-based model of

sexual behaviour. Published research, and the data from this study, also suggest that it is an increasing priority for clinicians to work skilfully with a diverse range of clients, including clients from non-normative populations (Barker & Langdridge, 2010b; Kleinplatz, 2012b). In light of this priority, the chapter also presents data on survey participants' use of critically oriented sex therapy principles, which may be of particular use in working with sexual 'minority' clients.

The chapter begins by discussing the subjective model of goal setting that appears to be prevalent amongst practitioners surveyed. Tables 7.1 and 7.2 (presented in appendices Q and R) outline the key themes and sub-themes on goal setting in the treatment of sexual dysfunction, identified in the qualitative data from this study. A substantial proportion of research participants hold that the *DSM* model, and the sexual response cycle that underlies it, represent a performance-based paradigm of sexual behaviour, with 32.4% of interviewees expressing a critical view of this performance-based model of sexual health. This type of performance-based standard, some argue, represents a narrow delimitation of sexual experience and may in itself impose performance pressure on the client. An equally considerable number of interviewees (32.4%) state that performance demand is a frequently observed causal or contributing factor in sexual dysfunction. From this critical viewpoint, data indicate that rigid or uniform application of *DSM* categories, or predetermined measures of sexual functioning, may actually have an adverse iatrogenic effect, entrenching performance-based standards, increasing the client's anxiety, and in some instances exacerbating the client's sexual problems (Abrahamson, Barlow, & Abrahamson, 1989; Barlow, 1986; Bruce & Barlow, 1990; McCabe et al., 2010; McCarthy & Thestrup, 2009b; Rowland, Georgoff, & Burnett, 2011).

Additionally, it is argued that social deconstruction/analysis of this model of sexual behaviour reveals a narrowly delimited heteronormative assumption of penetrative, genital sexuality. Sub-themes in the qualitative data include clinicians' concerns that conventional standards of sexual functioning are often orgasm-focused, and conflated with intercourse/penetration. Consequently, a number of interviewees explicitly rejecct the performance-oriented model of sexuality, as a de facto archetype of sexual functioning, in clinical practice. Instead of emphasizing performance, many clinicians emphasize the priority of desire/pleasure/satisfaction over arousal/orgasm/performance as the overarching goals of clinical sex therapy.

Collected data support the hypothesis that clinical goal setting in sex therapy tends to be flexible, subjective and client-specific. Milrod outlines a general

professional objective that appears to be common amongst psychosexual therapists; "my objective," she states, "is for the client to get what they came for" (research interview, 11/10/2012, transcript p. 12, line 22). Resnick shares this position, stating, "my objectives correspond to the client's objectives" (research interview, 04/11/2012, transcript p. 3, line 41). In this process, Williams indicates, a necessary first step is to "find out what they want. Where they feel they want to be" (research interview, 15/01/2013, transcript p. 4, lines 37-38). For many sex therapists, this type of appraisal of the client's subjective aims serves as the point of departure negotiating realistic goals and initiating therapy.

7.1.1. Goal setting Orientation: Client-led Goal Setting

Consequently, as indicated in the previous chapter, for a sizeable proportion of clinicians the initial diagnostic and assessment sessions may be guided by a fundamental, overarching question:

What does the client want?

Unlike many other categories of psychopathology, collected data indicate that objective clinical goals—such as symptom reduction, or increased functioning according to an accepted baseline—may be of limited applicability for many sex therapy clients. In sex therapy, "the starting point," for many clinicians, Perring states, "is: 'what can I do to help you?' And it's up to the individual to identify what it is they want to get out of seeing me" (research interview, 14/12/2012, transcript p. 7, lines 7-9).

Interview data indicate that many sex therapists begin with some variant of this question, with a considerable portion (41.2%) of interviewees alluding to the use of a client-led goal setting orientation. As one interviewee states, "usually the client identifies the objective" (Seavey, research interview, 01/02/2013, transcript p. 10, line 38),[32] and it appears that clinical objectives in sex therapy may be predominantly client-led, and defined in the client-therapist consultation, with the client often being viewed as the expert on the sexual problem.

In adhering to a client-led, and flexible goal setting process, a social constructionist framework of informed naivety, and beginning from a position of

[32] One important exception to this practice, highlighted by a number of interviewees, is in cases of criminal sexual behaviour, wherein a client has been referred for therapy by a court order (Ravella, research interview, 11/01/2013; Seabloom, research interview, 13/01/2013; Seavey, research interview, 01/02/2013). Psychotherapy for criminal sexual behaviour, interviewees stress, requires advance specialized training, and may fall outside most sex therapists' professional expertise (Braun-Harvey, research interview, 15/11/2012).

"not-knowing" may be useful (Anderson & Goolishian, 1992; Berry & Barker, 2014). Assuming a stance of informed naivety requires that the therapist bracket off their assumptions about the client's sexuality and clinical aims, to the greatest degree possible. "How can I be of help?"—the common refrain reported by survey participants as a first question at intake—accord well with this stance of not-knowing in a client-led goal setting process. Data indicate that many clinicians, guided by the client's unique and subjective aims, aim to provide assistance in setting feasible and well-articulated goals.

7.1.2. Emphasis on Setting Realistic Goals

The ethos of beneficence—an overarching desire to help the client live a happier, or 'better' life—is entrenched in the guidelines of the psychotherapy field, including the ethical mandates of the American Psychological Association, and appears foundational in the sex therapy field (Bancroft, 1981; Montorsi, Adaikan, et al., 2010; Tjeltveit, 2006; Watter, 2012). In the qualitative data gathered for this study, an underlying beneficent objective—to help foster a marked improvement in the client's life, particularly in the sexual and relational sphere—was a prominent theme.

The core aims defined by many sexual specialists appear to be oriented principally towards the role that sexuality plays in the client's life and relationships. "Here's my mantra: intimacy, touching and sexuality," McCarthy states, "My objective, my overriding objective is [to help] sex play a positive, integral role in your relationship. That's the overriding goal" (research interview, 17/01/2013, transcript p. 2, lines 26-28). McCarthy proceeds to emphasize that this, "isn't a rigid thing, like number of intercourses, or number of orgasms. It is much more this notion that we've found a couple's sexual style that really fits" (research interview, 17/01/2013, transcript p. 6, lines 41-43). Goal setting, then, appears to be shaped by a combination of the clinician's beneficent core principles—often expressed as helping to make sex a subjectively fulfilling and enriching part of the client's life—and client's specific subjective aims. Braun-Harvey explicitly highlights the need for balance between core principles and specific objectives in the goal setting process, stating: "it's individual, but it also straddles the line between being individual and also having to be based on some basic fundamentals of sexual health for everyone" (research interview, 15/11/2012, transcript p. 5, lines 20-22). Thus, while a broad desire to help the client attain a higher level of personal happiness, or subjective

satisfaction, may be a foundational motivation for many sex therapists, research participants emphasize that it must be balanced with the client's aims, in establishing clearly defined, specific and clinical goals.

While the therapist's overarching philosophy may emphasize pleasure and intimacy over performance-based objectives, it is noted that clients may often begin with a performance-based orientation to treatment. Consequently, a number of interviewees (44.1%) describe the framing of clinical goals as a process of collaboration, or negotiation, between client and therapist. In addition to emphasizing the importance of realistic therapy goals (and the therapist's role in ensuring the development of such goals, often by working to temper the client's initial performance aims), research participants indicate that it is common for clients to begin with unspecific or unrealistic goals. Williams indicates the inadequacy of vague beneficent objectives, and the necessity of clearly defined and feasible goals, stating, "I will negotiate on what they're saying. I have a lot of people say they just want to be happy. But I'm not going to take that. I can't do that. So it's based on [setting] realistic goals " (research interview, 15/01/2013, transcript p. 4, lines 45-46, p. 5, line 1). Knowles, however, illustrates that in some instances more specific sexual goals may also be infeasible. "One of the very important functions of the [sexual] history, and delivering that formulation," she states,

> is to negotiate realistically achieved goals. You know, so if I have a man who's coming in and saying, 'I want my erection'—and let's say he's in his sixties—'I want my erection to be what it was when we first got together.' I don't see that. You've been together for thirty years, it ain't gonna be this way. Let's be realistic. So there's something about making sure the goals that we negotiate together, either the individual or the couple, and me as their therapist, that they are realistically achievable. I would never wish to set anybody up for a fall…you may be amazed, or not, to hear how many people have totally unrealistic goals (Knowles, research interview, 30/01/2013, transcript, p. 5, lines 12-21).

Data shows that one of the therapist's principal roles in the goal setting stage is to assess—based on specialist expertise and clinical experience—the feasibility of the client's goals. "They set the goals," Seabloom states, "and I tell them whether the goals are achievable" (research interview, 13/01/2013, transcript p. 10, lines 41-42).

Establishing a case formulation that includes clear and realistic goals is described as a "synthesis," of goals, attained by identifying the client's aims, the

partner's aims, and the therapist's understanding of what is realistic or feasible (Gutteridge, research interview, 23/01/2013, transcript p. 12). Gathered data suggest that this process generally involves helping the client to understand and conceptualize the difficulty/problem, and then define a realistic set of objectives/priorities. In some instances, this may be the fundamental aim of the therapy process. As Openshaw states,

> sometimes my contract may be an exploratory contract, rather than a change contract…what I mean by that is: 'let's explore the significance of this'… not all of my contracts would be change-focused. Some might be about gaining greater understanding, which won't change anything other than understanding. It won't change the symptom necessarily (research interview, 26/02/2013, transcript p. 7, lines 9-23).

The data collected here suggest that whether an exploratory contract is negotiated, as Openshaw describes, or insight is sought as the basis for establishing sex therapy goals, the exploratory dimension of the sex therapy process is a focal element in the goal setting and case formulation phase. A related sub-theme in the qualitative data is the concept of acceptance, as a number of interviewees emphasize that it may often be beneficial for the clinician to emphasize acceptance to the client (especially before focusing on change) through the assessment and goal setting process.

In the exploratory stage of therapy there is a high priority placed on helping the client, or couple, to understand and conceptualize the difficulty/problem in a relationship context. This may include:

- identifying the partners' individual priorities and how they fit together (or are at odds with one another), with a view to synthesizing and negotiating viable goals,
- assessing unspoken motivations that the clients may or may not be aware of. This may be an individual's desire for something that's not been discussed with the partner (O'Connor, research interview, 07/02/2013), or desire for separation, etc. (Williams, research interview, 15/01/2013)
- identifying couple dynamics, which may include blaming, collusion, or the unconscious, mutual designation of one individual within the couple dyad as the carrier of the symptom (Hertlein, Weeks, & Gambescia, 2009)
- identifying defenses that are at play in the couple relationship (projection, projective identification, transference, denial etc.)(Daines, research interview, 31/03/2013; Daines & Perrett, 2000).

A useful methodology in this exploratory process is to help the client understand relationship factors as they are relevant to the sexual problems upon which the treatment focuses. As discussed in chapter 6, for a significant proportion of therapists, this process involves interpreting relationship factors as they may predispose, precipitate, or maintain sexual problems. Basson and Brotto, however, offer an expanded "Four P's" model, which prescribes examining: predisposing, precipitating, perpetuating, and *protective* factors in the client's sexual difficulties (2009, p. 134). Within this framework both the underlying causal/contributing variables, and resiliency/health factors—which may be used in working towards the clients' goals—are emphasized.

Data indicate that a clear and effective assessment/case formulation may help the couple to understand their sexual and relational problems. A clearly articulated case formulation may help to foster acceptance, and serve to normalize the sexual problem—a key psychosexual therapy principle, discussed at greater length below. Couples, Knowles states, may have a sense of relief when hearing the case formulation: "one of the things that couples are pleasantly surprised about," she states, "is: 'oh lord, when you say it all like that, and it's intense and it's condensed,' they go, 'oh lord, no wonder we're having a few problems'" (research interview, 30/01/2013, transcript p. 4, lines 39-41). This insight may help instil a therapeutically beneficial sense that the presenting sexual problem is normal, comprehensible, well defined, and amenable to therapeutic change.

In the absence of clearly established goals, it is emphasized, clinical progress is effectively impossible to assess. As such, data indicate that specific and explicit goals are the means for monitoring the therapeutic process, through consistent reference to the case formulation. The importance of specific and clearly defined objectives is a prominent sub-theme in the qualitative data, and serves as the foundation for the clinician's progress tracking throughout the therapy (another apparent theme in the data). One interviewee suggests that a best practice in psychosexual therapy is to consistently and explicitly refer to the objectives negotiated with the client. "Paperwork," he states, "just isn't a pain in the ass. It's also your ability to hold yourself accountable" (Winn, research interview, 16/01/2013, transcript p. 13, lines 14-15).

7.1.3. Emphasizing a Pleasure- and Desire-based Model of Sexual Behaviour

A substantial number of the sex therapists interviewed for this research emphasize the importance of the overall sexual experience, holding "desire and satisfaction as being more important than arousal and orgasm" (McCarthy, research interview, 17/01/2013, transcript p. 1, lines 28-29). As such, they stress that in many instances clients should be encouraged to focus on the broad experience of erotic pleasure instead of focusing solely on orgasm, duration, penile rigidity, or other quantitative, performance-based measures. By broadening the client's focus, it is held, therapists may help reduce the distress caused by sexual disorders. To this effect, Wincze and Carey suggest posing the question to patients:

> 'Why do you have sex?' With this question (or a similar one), we try to elicit a man's hopes and goals when he has sex. After some thought, most men can generate quite a number of reasons. 'To have pleasure' or 'because it feels good' may be men's most common responses. We point out that people have sex for a variety of reasons: to experience pleasure, to express love and affection, to make up after an argument, to have children, to make oneself feel better, to please a partner, and so on. Moreover, the reasons may change from occasion to occasion…the primary goal of our question and the ensuing discussion is to encourage the couple to focus on general pleasuring rather than orgasm (Wincze & Carey, 2001, pp. 152-153).

Through the use of this technique, the therapist in effect encourages reflective functioning/mentalizing in the client, as it pertains to the meaning of sex and sexuality within the wider context of the relationship (Allen, Electronic Article, retrieved on 10/04/2012).

Consistent with this principle, the data reveal that many clinicians may encourage the client to take a critical and reflective view on the widespread tendency to view sex as "an event-focused process, as opposed to a process of give and take" (Winn, research interview, 16/01/2013, transcript p. 10, lines 15-16). Savage defines this approach as a "pleasure model" (Savage, 1999), which holds that there is not a direct, predictable relationship between desire and arousal: "we can't just say it's the same as: 'if I desire, I have an erection'. That doesn't work" (Savage, research interview, 04/11/2012, transcript p. 10, lines 37-38). Instead, pleasure, desire and intimacy are proposed as key priorities for the client or couple (2007, p. 190; McCarthy & Thestrup, 2009b). This orientation differs from socially conventional

notions of masculine sexuality, which often privilege a performance-based standard of sexual behaviour. A significant number of men, McCarthy holds

> learn erection-intercourse-and-orgasm in a highly predictable, autonomous way—they don't need anything from their partner—and they see that as: that's the way. That's what real men do. That's the model in pornography, that's the model in movies. But that's not the truth…the reality is that sex by its nature tends to be variable, flexible, and have different roles and different meanings for people. And again, that's why I think desire plays such an important role. Because, you know in every sex movie you're going to see, it doesn't involve married couples, but it always involves the notion that both people are highly desirous, highly aroused, highly orgasmic. But again, if you look at real couples, both data-wise and clinically, that isn't the way it works at all. Couple sex tends to be really complex with different roles and different meanings (research interview, 17/01/2013, transcript p. 4, lines 34-36).

Overall, data suggest that, despite the marked subjective differences between clients and couples, many sex therapists broadly emphasize the importance of pleasure, desire and intimacy in the couple relationship, stressing that these factors often are more adaptive and functional priorities than performance or adherence to a conventional sexual response cycle model.

7.1.4. Shifting Goals: Working with an Evolving Case Formulation

As outlined above, in the assessment and case formulation, for many therapists, helping clients set clear and realistic goals is a primary objective. Within this model, the therapist works throughout the therapy process to maintain focus on the goals established in the assessment phase, but also to help the client understand the shifting nature of their goals. Fonagy provides an overview of the clinical insight that the psychotherapist applies in setting goals and subsequently measuring therapy progress, stating:

> measuring outcomes, and measuring progress powerfully interfaces with normalization—that the expectations the people have about their lives change—and something that initially would have seemed to them utterly unsatisfactory as an outcome becomes, actually, a very good outcome. But if you tell them that at the very beginning, that, 'this is all we're going to be able to achieve here', then you don't get very far. What might happen is that

> they drop out. It's part of the work of, I think, an experienced and reasonable therapist, with relatively collaborative patients, is to have in their mind, what is achievable, negotiate a contract, which I deeply believe in, that is consistent both with the patient's expectations and hopes at the first phases of a treatment, and the therapist's experience for what is realistically achievable, and you negotiate something that actually is consistent with both, and then you work towards that end. So, it becomes a collaborative and common aim (research interview, 04/04/2012, transcript p. 7, lines 31-44).

This illustrates an important element of the sex therapy framework: rather than fixed goals, clinical practice appears to be largely based on evolving goals, which may often change throughout the therapy process, and require consistent monitoring and assessment throughout the therapy. Barker, who describes this model as "a *shifting formulation*", states,

> Whilst we've got... that original desire to, say, start getting erections or whatever it might be…people often find that actually the goals that they have at the beginning do shift over the process, and the outcome of this might be: yes, you know, you find a way to start having these erections that you want, fine. But it might be more that you begin to see: actually there's other things I can do without an erection. Or it might be something in the middle (Barker, research interview, 30/03/2012, transcript p. 8, lines 15-22).

The use of this type of *shifting formulation*—a case formulation, inclusive of clinical goals, that changes as the therapy progresses, by virtue of progress made, blocks or obstacles encountered, or changes in the client's priorities—is a prominent theme in the qualitative data. Gutteridge indicates that this type of formulation may be operationalized within a short-term goal setting process, that affords an opportunity to regularly re-evaluate therapeutic progress, and revise goals. Within this clinical model, she states,

> it's always in [the client's] control to say: well this is good enough for us, you know, we've got as far as we want to go for the moment. Even though they might not have achieved the ideal sex life, or the perfect sex life, for their imagination of what their sex life might be like, but for the moment their relationship has improved sufficiently for them to want to live with that for a while, see what they want to do next (Gutteridge, research interview, 23/01/2013, transcript p. 2, lines 16-21).

The shifting formulation model appears to accord with a wider conceptualization of the client's subjective identity (discussed later in this chapter), as dynamic, fluid and changing. As one interviewee states "the objective is as fluid as your sexual practices may be" (Winn, research interview, 16/01/2013, transcript p. 12, lines 29-30). As the following sections discuss, the dynamic/shifting quality of clinical goals is also linked with the fluidity of the client's sexual identity.

7.2. Critical Sex Therapy: Working with Sexual Diversity

One particularly prominent question in this research is: what strategies enable therapists to work with such a wide variety of issues, and such a substantial range of client diversity? This section outlines data on some of the main challenges in working with diverse and sexual 'minority' groups, and provides an overview of some of the core techniques that may be usefully applied in working critically with a wide range of client identities and behaviours, including 'minority' groups. The section describes techniques identified in the data, which include: the use of reflective practice, nonjudgmental acceptance, use of social constructionist theory, normalizing, horizontalizing, and affirming. Tables 7.3 and 7.4 (presented in appendices S and T) describe the key themes and sub-themes, identified in the qualitative data from this study, on working with client diversity from a critical sex therapy framework.

7.2.1. Clinical Strategies for Working with 'Minority' Sexual Populations

A number of research participants emphasize that 'minority' sexual populations are not necessarily minorities in a statistical sense. Instead the term 'minority' may often be used as a euphemistic referent for populations that are marginalized or under-represented in dominant discourses. While survey participants express a generally high level of sensitivity to sexual diversity issues, a dyadic male-female, monogamy-based relationship paradigm is prevalent in the qualitative data—a tendency reflected in much of the wider clinical discourse and research literature. However, a number of critically-oriented research participants emphasize the importance of examining sexual diversity issues—including working with LGBTQ, openly non-monogamous, and BDSM clients—and describe the unique competencies required when working with diverse client populations. The following sections address some of the specific issues involved in working with diverse client groups that were evinced in the qualitative data.

7.2.2. Sex, Gender, and Normativity: Qualitative Interview Results

Clients' expectations about sex are identified as a crucial, defining element of the therapeutic process. As discussed above, clients' expectations are shaped by socio-cultural influences, and may often take the form of particular (esp. performance-based) expectations about sexual behaviour, which rely on a taken-for-granted view of the sexual response cycle. Additionally, the qualitative data suggest that clients may often hold a narrowly delimited view of healthy sexuality and appropriate sexual behaviour. This "narrow view of what sex should involve" Barker stresses,

> leads to them trying to only do a certain kind of narrow range of things. And of course, if those things don't really do it for them, or if they become so tuned into the other person that they can't really tune into themselves at all—or what they might desire—because they have to keep it in such a narrow range, then that's really common (research interview, 30/03/2012, transcript p. 5, lines 30-36).

The data suggest that this narrow view of sexuality is largely defined by the culturally pervasive assumption that healthy individuals tend to: A) desire to be sexually active and B) conform to a particular, well-defined set of sexual behaviours. A number of interviewees, and a wider body of published research, hold that this circumscribed, culturally specific perspective serves to restrict normative standards of sexuality to a particular set of behaviours, and a largely predetermined set of personal meanings, marked by:

- Heteronormativity—which privileges heterosexual relationships, implicitly or explicitly devaluing non-heterosexuality,
- Mononormativity—which sets monogamous unions as the de facto standard for sexual relationships,
- Presumption of male-active/female-passive sexuality, and
- Presumption that the desire/drive to have sex is a necessary criterion of normal/healthy sexuality (which opposes asexuality, and pathologizes/stigmatizes low levels of desire or sexual initiative)(Barker, research interview, 30/03/2012; Barker, 2005; Barker & Langdridge, 2010a, 2010b; Berry & Barker, 2014; Braun-Harvey, research interview, 15/11/2012; Winn, research interview, 16/01/2013).

Interview data suggest that the pressure to conform to these culturally sanctioned standards of sexual behaviour is often an influential factor in the sex therapy process

and that these normative pressures may influence both clients *and* therapists (including sex therapy specialists). While a growing body of critical scholarship on asexuality (Bogaert, 2004; Prause & Graham, 2007), and non-normative sexualities (Barker & Langdridge, 2010a) has begun to draw attention to, and challenge, the perceived normative biases of sexual psychotherapy, it is widely agreed that this is an important area for further research.

In the clinical arena, a goal that many interviewees view as foundational is: fostering a critical and reflective examination of what the client really wants to attain through sex therapy. In many instances, this task involves a close evaluation, or re-evaluation, of the client's initial goals, to determine how they fit with the client's personal, and relational priorities. A relevant associated theme in the qualitative data is: emphasis on the possible need to affirm non-normative identities. Interviewees stress that internalized homophobia, and other forms of internalized prejudice, may influence clients' initial goals, and are an important consideration in the therapy process. Consequently, a number (14.7%) of interviewees recommend the use of permission-giving as a client-affirmative clinical technique. Additionally, the therapist's use of a critical and self-reflective stance (an issue addressed at greater length in section 7.2.8.) was identified as a sub-theme within the practice of affirmative sex therapy with diverse clients. In order to meaningfully affirm diverse clients, the data indicate, it is considered necessary for the therapist to identify and address their own biases/prejudices, which may often extent to 'minority' clients with whom they work.

The data also suggest that a sense of alienation or disconnection from one's sexuality, or one's deeper sexual desires/preferences may not be uncommon for sexual 'minority' clients, and may be the consequence of socially conditioned messages about normal sexual behaviour. This experience of sexual prohibitions, may often contribute to the comorbid/contributing experience of depression and anxiety that many clients face. Barker attributes this phenomenon, in part, to the internalization of a "critical voice", which delimits a restrictive range of socially allowable sexual behaviours and identities, condemning the client's decision to engage in behaviours that deviate from this spectrum, and even condemning the fundamental identity that underlies these desires, fostering internal conflict about the condemned aspects of the client's sexuality/identity. Another relevant sub-theme is apparent in some interviewees' (11.8%) emphasis on the importance of personal authenticity. The qualitative data appear to reflect an implicit assumption that

valid/viable clinical goals—often linked to the values of self-actualization, and personal fulfilment—depend on helping the client identify and negotiate core identity aspects. This apparently prevalent conceptualization links to, and expands upon, the fundamental guiding question in the goal-setting process: what does the client want? In addition, the data suggest, it is essential to ask: how can the client be/become authentic in their sexuality and identity? Helping the client to answer these questions honestly, in light of the restrictive influences outlined above, may be seen as a key practice in critical sex therapy.

7.2.3. Sex Therapy and Non-Normative Clients: Qualitative Interview Results

A significant proportion of the sex therapists interviewed for this research project spoke of their clinical practice from a principally heterosexual vantage point. References to non-heterosexual (or otherwise non-conforming) clients were largely limited to sub-specialist practitioners who work specifically with alternative population groups including: lesbian, gay, bisexual, trans., and queer clients, openly non-monogamous clients, and BDSM clients. To a large degree, this trend may reflect participants' tendency to generalize from their own clinical experience, and may reflect the fact that the majority of research participants work primarily with heterosexual clients (although more research is needed to determine whether this is a valid hypothesis). Nonetheless, it must be noted that a number of interviewees make reference to the degree to which the clinical principles they address might be generalized from heterosexual, and behaviourally normative, client populations to 'minority' client groups. A number also share their thoughts on the possible limitations of such approaches in working with non-normative client groups, highlighting the differences that may obtain when working with such clients.

A point of concern, however, is the ostensively widespread limitation in general psychotherapy training, identified by a number of specialist interviewees and in the wider literature (Barker, research interview, 30/03/2012; Braun-Harvey, research interview, 15/11/2012; Britton, research interview, 07/03/2012). Research suggests that psychotherapy generalists may often be undertrained in sexual psychotherapy and uncomfortable addressing sexual issues with their clients (Haboubi & Lincoln, 2003). With respect to LGB populations specifically, Evans and Barker hold,

> research over the past decade has consistently confirmed that the majority of therapists are ill-equipped to work with lesbian, gay and bisexual (LGB)

> clients, having had little training on the topic of sexuality, and often expressing a lack of knowledge about such clients (2010, p. 375).

Such training limitations and personal discomfort may also extend to specialist groups—such as couple and relationship therapists—for whom client sexuality may be a more immediate clinical issue. Ravella suggests that it may be relatively common for a couple or relationship counsellor to avoid a concerted discussion of sexual issues in general (research interview, 11/01/2013). Even for sex therapists working with LGBTQ clients, Britton suggests, it may be the case that "few have the background, the training, the sensitization, the language, the understanding, and the ok-ness with being able to ask the right questions" (Britton, research interview, 07/03/2012, transcript p. 3, lines 26-28). This factor is a main impetus for the high emphasis on advanced specialization training and professional development, evident in the research findings. Data suggests that part of the diagnostic challenge when working with LGBTQ clients may also be systemic: it is held that the *DSM* diagnostic categories are, in and of themselves, heterosexually biased, being based on a heterosexual response-cycle model of penetrative sexuality.

7.2.4. Sex Therapy and Non-Normative Clients: Discussion of Results

In light of the research findings outlined above, an emergent challenge was: to determine how sex therapists can work effectively with a diverse range of clients, and to identify the clinical practices sex therapists use in dealing with non-normative clients. Analysis of survey data illustrates a number of key techniques that may facilitate critical and reflective diagnosis and treatment in the psychosexual therapy context. In working with diverse clients, four main clinician attributes are highly emphasized by interviewees:

1) a nonjudgmental stance towards diverse clients,
2) an understanding of diversity—in particular, understanding the wide variety of possible identities that a client may have, and the specific challenges that are likely to be associated with these identities,
3) an appreciation of fluidity—recognition that the client's identity, behaviours and therapy goals are apt to change over time,
4) a reflective, self-critical approach to practice—a commitment to reflective practice, self-monitoring/introspection, and recognition of broad values and possible prejudices, as well as situation-specific responses to particular clients.

The data suggest that the clinician's understanding of diversity is rooted in an individually specific understanding of the identity categories that a client may occupy within the parameters of social discourse. It is emphasized that the clinician's perspective (like the client's) is influenced by the clinician's subjective social and cultural background, which may contribute to the development of personal prejudices. Consequently, reflective, self-critical practice is emphasized, alongside an understanding of diversity, and acknowledgment of the fluidity of the client's identity and sexuality. Appreciation of fluidity involves breaking down and challenging dominant identity categories, addressing the client in a highly individuated way in order to understand them on their own terms, and potentially working to overcome or counteract some of the restraints of dominant discourse. Additionally, a key point—discussed at length below—is the high level of commitment to maintaining a nonjudgmental stance, salient in the quantitative data.

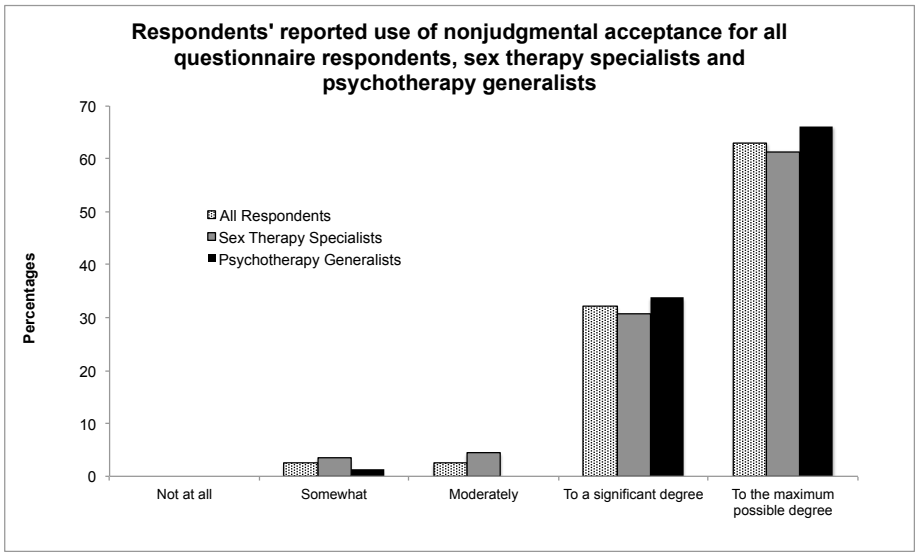
7.2.5. Clinicians' use of Nonjudgmental Acceptance: Questionnaire Results

A crucial foundational technique in contemporary psychotherapy is: the assumption of a *stance of nonjudgmental acceptance towards the client*. This clinical orientation is identified by Ablon and Jones (Ablon & Jones, 1998) as a prototypical technique in psychodynamic psychotherapy, although it also has a significant place in a wide range of other psychotherapy models, in particular humanistic and person-centred therapy models (Rogers, 1957; Rogers, 1959; Rogers, 1980). Table 7.5 and figure 7.1 show the research participants' responses to the question "in the most recent case of male sexual dysfunction you treated, to what extent did you work to convey a sense of nonjudgmental acceptance, measured on a Likert scale ranging from 1—'not at all' to 5—'to the maximum possible degree'. An independent sample t-test was performed, which demonstrated no statistically significant difference in the degree to which sex therapy specialists ($M = 4.5$) and psychotherapy generalists ($M = 4.6$), report using a nonjudgmentally acceptant model of practice with their most recent relevant client, $t(157) = -1.118$, $p < .265$.

Table 7.5
Extent to which respondents report working to convey a sense of nonjudgmenal acceptance with most recent client, for all questionnaire respondents, sex therapy specialists (ST) and psychotherapy generalists (PG)

	Total Frequency	Percent (%)	Frequency (ST)	Percent (%)	Frequency (PG)	Percent (%)
Extent to which respondents use nonjudgmental stance						
Not at all	0	0.0	0	0.0	0	0.0
Somewhat	4	2.5	3	3.4	1	1.4
Moderately	4	2.5	4	4.5	0	0.0
To a significant degree	51	32.1	27	30.7	24	33.8
To the maximum possible degree	100	62.9	54	61.4	47	66.2
Total	*159*	*100*	*88*	*100*	*71*	*100*

Figure 7.1: Respondents' reported use of nonjudgmental acceptance for all questionnaire respondents, sex therapy specialists and psychotherapy generalists



This data strongly supports the hypothesis that a stance of nonjudgmental acceptance is a widespread clinical technique amongst psychotherapists surveyed. A nonjudgmental and acceptant orientation towards the client is almost universally endorsed by sex therapists surveyed in this research project, irrespective of their declared psychotherapeutic school.

7.2.6. Key Principles in Critical Sex Therapy: Discussion of Qualitative and Quantitative Results

In conjunction with a nonjudgmental orientation, the data suggest that a high level of literacy and knowledge about sexual diversity is a key therapist attribute when dealing with sex therapy clients in general, and non-normative clients in particular. We may identify the need for familiarity with: diversity, the core issues that specific client groups commonly face, and the specific language clients may use. The importance of familiar understanding is illustrated by the fact that sexual 'minority' is a problematic term, since, as stated above, it presupposes that LGBTQ individuals, and other sexualities outside the hegemonic norm, are statistically uncommon, obscuring the reality of sexual variance. As Barker emphasizes, while there is a culturally situated, widespread perception of LGBT, asexual, bdsm, non-monogamous, and queer individuals as being 'minority' sexuality, they're "not actually minority in all cases;" consequently, rather than comprising an *actual* or statistical minority, these groups constitute a distinct conceptual category—

constituting "what is *seen as* minority sexuality or gender" (Barker, research interview, 30/03/2012, transcript p. 18, lines 33-34).

In addition to understanding such internal biases in the discourses about sexuality, it is important for the therapist to have a strong understanding of the subjective experiences clients may likely face. In working with gay male clients, for instance, Britton illustrates the importance of specialized knowledge, stating,

> if I don't even know the words, how can a guy who's gay feel comfortable asking me "am I ok? Am I normal? How do I get past this? This is something I'm longing for."? I have to have that nuanced background myself (Britton, research interview, 07/03/2012, transcript p. 3, lines 7-9).

Specialist familiarity pertains to the intersections of a number of social factors, including: sexuality, race, class, gender and other variables. In this respect, attentiveness to the unique challenges particular clients may face, based on early life experiences is of eminent importance. As a number of interviewees point out, different social milieus, including sub-cultural groups and social classes, may respond very differently to sexual factors and diverse sexual identities, with clients facing varying levels of stigma and shaming, based on their social background.

7.2.7. Key Principles in Critical Sex Therapy: Social Constructionism, Normalizing, Horizontalizing and Affirming

The data from this study provide evidence that critical *social constructionist theory* can be an invaluable diagnostic and psychotherapeutic tool, which may help the therapist to understand the client's unique background and personal experiences. By focusing on the significant social and cultural variables that impact on a client's sexuality and relationship, it may be possible to identify elements that inhibit or strengthen the client's sexuality, and contextualize the role that socio-cultural factors play both in the patient's life and in the therapy process. Interviewees suggest that it is vital that the therapist works to maintain a sense of the dominant discourses that affect their clients, "knowing the sort of world that [their] clients are likely operating within" (Barker, research interview, 30/03/2012, transcript p. 4, line 19). This technique requires acknowledgement that sexual difficulties often occur within interpersonal social relationships, and are situated within a socio-cultural context. A crucial factor when evaluating the sexual concerns of a non-normative client, therefore, may be in interpreting the client's socio cultural milieu, evaluating how the

client's sexual difficulties may be rooted in their social setting, and how this may affect them—with or without their awareness.

Thematic analysis of interview data revealed *normalizing* as another key technique, which a substantial proportion of research participants (38.2%) emphasize as a crucial clinical practice—both in diagnosing/assessing clients, and throughout the treatment process. The technique of normalizing, as it is described in the qualitative data, involves several dimensions, including—helping the client to conceive of sexual problems as understandable and natural responses to psychological and relational factors, and helping the client to develop a flexible perspective on sexual behaviour, which reduces the level of stigma that may be associated with social standards of sexual behaviour and normality. Therefore, according to questionnaire data, normalizing entails a number of facets, including:

- explicitly questioning normative standards of sexual behaviour, under the assumption that imposing normative frameworks on clients' sexual behaviour may produce iatrogenic injury (Winn, research interview, 16/01/2013),
- normalizing the client's sexual identity, and possible fluidity of this identity (Barker, research interview, 30/03/2012),
- emphasizing that the client's sexual difficulties and problems are normal responses to their current life circumstances, and in relation to what other people might experience in such circumstances (Dunn, research interview, 29/01/2013; Fonagy, research interview, 04/04/2012).
- fostering a clinical environment in which the discussion of sexual issues and sexual problems is experienced as natural/appropriate (Hertlein, Weeks & Sendak, 2009; Milrod, research interview, 11/20/2012; Savage, research interview, 04/11/2012) ,
- situating clinical work within a context of critical research that self-consciously aims to challenge dominant standards of sexual normality, which are often seen as restrictive and damaging to the client's clinical aims (Barker, research interview, 30/03/2012; Kleinplatz, 1996; Mahrer, 2012; Ravella, research interview, 11/01/2013; Tiefer, 1996).

Levine's "first principle of clinical sexuality" clearly indicates the importance of social and cultural discourses, which define categories of normality and abnormality that strongly influence the client's sexuality, and impact powerfully on sexual functioning (Levine, 2007b). Consequently, as Fonagy emphasizes, "across orientations, across modalities, *normalizing* is a terrifically important part of what a

psychotherapist does" (research interview, 04/04/2012, transcript p. 7, lines 30-31). Normalization, for many interviewees, appears to serve a de-stigmatizing function, helping to problematize the expectations surrounding sexual behaviour that contribute to the client's sexual problem, or their subjective cognitive and affective experience of a perceived sexual dysfunction.

It is possible to identify two sexually specific aspects of normalization as a diagnostic and therapeutic technique: normalization of the client's sexual identity and behaviours and normalization of the client's sexual difficulties. Normalizing the client's identity and desires/behaviours, serves an important "permission-giving" function, intended to help reduce the guilt or shame that may be implicated in the client's sexuality. Normalizing the difficulties that have brought the client to therapy, Barker points out, is largely a matter "of saying: look, everyone who comes here struggles with this kind of stuff. It's not, really, it's not just you. It's kind of everybody" (Barker, research interview, 30/03/2012, transcript p. 7, lines 29-30). The data suggest that normalization is frequently supported by the use of psychoeducational techniques. Of particular importance is the critical stance towards categories of normality that the clinician models in the therapeutic encounter. As a number of interviewees indicate, normalizing should not result in the reification of categories of normality (i.e. by situating the client within the norm, and by implication positioning other behaviours as abnormal). Rather, normalization entails critically examining, or deconstructing, the client's sense of abnormality, and problematizing/challenging the taken-for-granted notions of normality that affect the client's sexual problems.

Interview data indicate that the application of social constructionist theory, and the therapist's attempts to interpret and normalize the client's sexuality and sexual problems, may generally involve a detailed sexual history taking, including examination of the client's family of origin, community experience, and early and ongoing messages surrounding sexuality. For LGBTQ clients, for example, it may be especially important to evaluate the early messages the client encountered in their family of origin, regarding sexual orientation, including the possible influence of heteronormative models of sexuality. A vital benefit of using social constructionist theory is to help the client situate their sexual difficulties within the context of their own life. In this regard, working with social constructionist theory may compel the therapist to begin with the sexual problem presented by the client, and expand

outwards, reflecting wider relationship issues, or a more expansive range of psychosocial concerns.

More broadly, evaluating the social and relational context of sexuality and sexual difficulties vis-à-vis social constructionism entails rendering explicit that which is implicit in a person's life, by exploring the way that social messages and values may have been internalized by the client, both with and without the client's awareness. Since many internalized social scripts and mores may affect the individual both consciously and unconsciously, it may be hypothesized that the social constructionist approach may benefit from a psychodynamic orientation, which seeks to help the client reflectively evaluate how they have been unconsciously affected by normative and dominant discourses, implicating a discussion of the individual's past and formative experiences, or a deeper discussion of the patient's sexual history and its prospective unconscious influences.

By situating the client's sexual difficulties within the wider context of their life, the therapist utilizes another critical psychotherapeutic technique: *horizontalizing* (Berry & Barker, 2014). Horizontalizing entails situating the client's specific concern (i.e. a sexual problem/dysfunction) within the wider "horizon" of their lived experience, rather than focusing strictly on the clinical issue. Additionally, the clinician seeks to understand and work with specific salient aspects of the client identity (for instance, sexual 'minority' status, or a non-normative sexual identity) within the wider psychosocial horizon. Thus, in horizontalizing the therapist refrains from treating the client's sexual problems or sexual identity as the sole issue of importance in the therapy. Rather, a horizontalizing approach to the therapeutic encounter involves interpreting the client, and their clinical concerns, as complex, multidimensional and non-static. As Barker suggests, within this model, "you're not seeing a person in front of you and thinking 'they're a lesbian', 'they're a heterosexual', 'they're asexual', 'they're kinky'. It's much more like…seeing that person as diverse, as ever-changing, as plural" (Barker, research interview, 30/03/2012, transcript p. 18, lines 45-46, p. 19, line 1). Sex, sexuality, and sexual problems, though very important, are considered to be only *parts* of the clinical picture.

Horizontalizing may be of particular value for clients who themselves have come to see a single—and often stigmatized—aspect of their sexuality as being singularly important or focal. The data from this study suggest that this type of singular fixation may in fact serve to impede clinical work, particularly where clients

experience shame or internalized prejudice associated with some aspect of their sexuality. Additionally, the "gay affirmative therapy" model—which aims to provide a "positive framework" for clinical practice that serves to affirm and validate LGBTQ identities—offers a critical framework for working with non-normative clients, and diverse sexualities (Davies, 1996). Published research has shown that affirmative therapy can help counteract experiences of stigmatization or disaffirmation that the client has experienced, and potentially counteract damage to the client's self-esteem, which the qualitative data from this study indicate may be a concern for some non-normative clients (Bigner, 2012; de Vries, research interview, 05/02/2013; Rutter, 2012). Consequently, affirmative therapy may serve an immediately therapeutic effect, in addition to fostering the conditions for more effective psychotherapy, by enabling the client to engage directly with issues that may have otherwise been (consciously or unconsciously) avoided.

As Langdridge states, the affirmative model requires the therapist to acknowledge and work with the dual impact that the psychotherapist and the wider socio-cultural world have on the client's sexual identity (Langdridge, 2007). Consequently, this therapeutic technique requires a high level of self-reflective awareness and critical engagement with the socially constructed aspects of the client's identity, the clinician's identity, and the context of the clinical encounter.

7.2.8. Use of Reflective Practice & Emphasis on Reflective Functioning

A high level of importance is placed on therapists developing and maintaining a clear understanding of their own views of, and position on, non-normative sexualities. While there is a widespread language of 'openness,' and agreement on the importance of psychotherapist 'nonjudgmentality' within the data, Winn emphasizes that such terms are not self-evidently meaningful. A critically self-aware understanding of—and ability to articulate—what is intended by "open and supportive" counselling is identified as an essential attribute in working with sexual 'minority' clients. While it is commonly assumed that openness, supportiveness and nonjudgmentality are self-evidently meaningful, and self-evidently useful, therapist qualities, Winn stresses the inherent danger of this perspective. The "position of being open and supportive," he emphasizes "is a potentially iatrogenic injury to your client, if they don't understand what you mean, or you can't define what that means" (Winn, research interview, 16/01/2013, transcript p. 3, lines 31-33). According to Winn, a self-congratulatory *belief* in one's own reflexivity and openness is at best

useless, and at worst damaging to the client, unless it is substantiated by a well-developed reflective practice and an effective method for conveying openness/support to the client.

The therapist's ongoing reflective practice and critical self-evaluation are identified in both the qualitative data and the wider published research as foundations for a well-articulated, open, nonjudgmental and supportive stance (Mann, Gordon, & MacLeod, 2009; Stedmon & Dallos, 2009). While the therapist's reflective practice may be a particularly important practical issue in working with diverse and non-normative clients, the core principles and techniques of self-reflection are of high importance with all clients and clinical issues. The qualitative data reveal a number of tools that may be usefully implemented in the therapist's practice, to foster critical self-reflection. Such tools include journaling, mindfulness practice, or the therapist's own psychotherapy/counselling (Berry & Barker, 2014). In addition, interview data suggest that many therapists view clinical supervision and professional dialogue with colleagues as effective tools, which are often used to gain perspective on clinical practice, to gain insight into their own cognitive and affective responses to the therapy encounter, and to analyze transference and counter-transference processes.

Alman, a highly experienced psychosexual therapist working within a principally cognitive behavioural framework, stresses the importance of self-reflective practice, and illustrates the pragmatic challenges of nonjudgmentality that the clinician may encounter. Genuine acceptance, she states, is

> a necessity if you're a sex therapist. You can't even have that: you'd want to do *what*?—kind of response inside, let alone express it…So I feel if a [therapist] knows that they can't deal with certain issues, then they shouldn't. It's a moral responsibility not to take clients who play in BDSM, for instance, if [the therapist] find[s] that personally repugnant (Alman, research interview, 09/01/2013, transcript p. 11, lines 15-21).

This conceptualization of moral responsibility implies another technique: *refusing to accept a client, or terminating the therapy process in instances where a self-perceived bias/prejudice threatens to compromise the treatment*. This technique appears to be strongly linked with self-reflective practice, as it presupposes recognition of one's own biases and clinical limitations. There is a clear ethical mandate that psychotherapists refrain from administering psychotherapy services that are apt to be ineffectual, or damaging to the client, entrenched in the ethical protocols of the psychotherapy profession (M. Leach & Harbin, 1997; Welfel, 2012).

However, further research in this area is needed, in order to: 1) assess the overall use and efficacy of self-reflective practice amongst clinicians, 2) determine how therapists might refuse to treat a client without adding indirectly to the stigma associated with the client's sexuality/identity, and 3) assess psychotherapists' competencies in identifying their own subjective biases, especially in working with sexual problems.

Finally, a diagnostic and treatment framework that appears to be especially common amongst research participants is *emphasis on a non-pathologizing model, or use of a sexual health model.* Often used conjunctively, alongside normalizing, and within a stance of non-judgmental acceptance, the sexual health (non-pathologizing) model emphasizes that many sexual concerns fall within the range of normal/healthy sexual functioning, and informs the critical orientation to standard diagnostic systems described in chapter 6. Within this framework, there is a self-conscious attempt to avoid the language of pathology, and "the defining baseline [for a clinically treatable sexual issue] is whether it's a problem for them or not" (de Vries, research interview, 05/02/2013, transcript p. 2, lines 7-8). Braun-Harvey, who works exclusively with men, and specializes in the outpatient treatment of men with concerns of out-of-control sexual behaviour, describes his use of the sexual health model, stating:

> I work from a sexual health perspective…I don't do out-of-control sexual behaviour as a sexual disease, or disorder. I don't use the terminology of addiction or, you know, another kind of disorder or disease perspective. I see it as on the continuum of worry-problem-and-disorder, as see it as, on the continuum, a sexual *problem*, not a sexual disorder or dysfunction, or a psychiatric diagnosis" (research interview, 15/11/2012, transcript p. 3, lines 43-45, p. 4, lines 4-8).

As discussed in chapter six, for many psychosexual therapists working within an anti-pathologizing, or sexual-health, framework, the diagnostic language used in conventional psychodiagnostics is inherently problematic. Many interviewees who use this model emphasize the distinction between 'problem' and 'dysfunction,' stressing that the language employed in *DSM* is intrinsically pathologizing, as it casts variant sexuality and sexual behaviour as dysfunctional/pathological. Table 7.6 provides a summary of critical sex therapy techniques drawn from the qualitative interview data, and relevant outside research, which are seen to be of particular utility in working with sexually diverse clients and client populations.

Table 7.6
Summary of Critical Sex Therapy Techniques Identified by Interview Participants

• Maintaining a stance of nonjudgmental acceptance
• Ensuring familiarity with sexual diversity
• Use of social constructionist analysis
• Normalizing (i.e. the client's sexuality and/or sexual problem)
• Horizontalizing (conceptualizing the client's sexuality within the wider horizon of their identity)
• Affirming-as-necessary (esp. affirming the client's identity and subjective experiences)
• Emphasis on reflective practice (for both practitioner and client)
• Refuse to take on a client—(in cases of self-identified bias/prejudice)
• Maintaining a non-pathologizing stance

7.3. Goal Setting and Case Formulation: Summary of Findings

Client diversity, and the strategies involved in working with varied client groups, is an important area for current research. The data presented in chapter 7 are intended to illustrate some of the principles and practices that may be of use in this area. It is important to acknowledge that the clinical practices outlined here are a modest contribution, and that this aspect of clinical practice warrants considerable further research (an issue discussed further in section 10.5 below).

This chapter has also described some of the more general guiding principles of goal setting and case formulation suggested by the data of this study. In addition to a subjective orientation, in which the client's unique identity and priorities are emphasized, the data suggest a high level of emphasis on pleasure and desire (instead of performance) and establishing/negotiating realistic goals as overarching clinical aims. An aspect of case formulation that appears particularly important in the data is the emphasis on reflective practice and reflective functioning. As with the clinical practices in diagnosis and assessment described in chapter six, reflective practice and reflective functioning are oriented towards fostering client insight. As the following chapter shows, the emphasis on reflective, insight-oriented practice also appears to extend to clinicians' theories on the aetiological factors that underlie sexual problems.

CHAPTER 8. EVALUATING THE AETIOLOGY OF MALE SEXUAL DYSFUNCTION

8.1. Introduction: Evaluating the Aetiology of Male Sexual Dysfunction—Multiplicity of Causal factors

The data presented in chapters 6 and 7 suggest that many clinicians view insight into, and understanding of, the conscious and unconscious causal factors underlying clients' sexual problems as an essential component of successful treatment. For this reason, it is essential to consider clinicians' aetiological theories on sexual dysfunction, in order to accurately understand the work they do and the role that psychodynamic theory/practice play in this work. As shown in the previous chapters, the influence of early life and family of origin factors is considered fundamental in the aetiological course of sexual problems. This chapter examines the aetiological theories that appear as prevalent in the data, and clarifies some of the psychosocial processes throughout the client's life course that are seen as essential contributors to sexual functioning.

Data from research interviews, on the aetiological aspects of male sexual dysfunction, are presented in table 8.1 and table 8.2 (appendices U and V). While this chapter focuses on the main psychological and social factors that are seen as contributing to male sexual problems, it is important to recall that these are seen within the context of the biopsychosocial model emphasized in previous chapters. It is equally important to note that this is a non-exhaustive discussion of aetiological/causal factors in male sexual dysfunction; while the primary causes that were emphasized by survey participants are described here, one of the important findings of this research is that the causal profile of male sexual dysfunction is multi-factorial, and follows an often complex and non-uniform course.

One interviewee succinctly captures a common research theme—skepticism about the sufficiency of singular causal theories. "I worry about the word 'cause'," she states, "because that implies that there's [only] one answer and there isn't, you know? There are many, many answers" (Milrod, research interview, 11/10/2012, transcript p. 3, lines 10-11). Data from this study show that disambiguating the complex causal picture of the client's sexual dysfunction, and identifying as many as possible of the multiple "answers" Milrod alludes to, becomes a primary task of the psychotherapist, and—insofar as 'insight' is identified as a key therapeutic objective amongst a majority of psychotherapists surveyed (as illustrated in chapter 6, section

6.4.1 and discussed throughout chapters 8 and 9)—a key therapeutic learning for the client.

The notion that both immediate and deeper influences underlie men's sexual problems persists in the clinical literature, and is evident in the qualitative data in this study (Kaplan, 1974b; Kaplan, 1987; Plaut, Graziottin, & Heaton, 2004). Immediate factors are qualified as current or recent aspects of the individual's life history, readily identified, and relatively straightforward to work with through established (and often cognitive behavioural) techniques (Kaplan, 1974b). Research participants suggest that immediate causal factors may encompass relationship stress, negative sexual experiences especially in the current relationship, outside stressors, lack of privacy, and knowledge/skills deficits amongst a host of other elements. Deeper causes are seen as encompassing unconscious or preconscious factors in the individual's psychology or relationship orientation (including unconscious thoughts and feelings towards the self, towards the partner, and/or towards other relationships inclusive of past and early life relationships). It is noted that deeper causes may also include positive and/or adaptive aspects of the symptoms. For instance, a number of interviewees identify ambivalent or conflicted feelings towards sex or towards the partner, in which pro-sexual and anti-sexual thoughts may conflict, as contributing to the underlying unconscious aspects of the sexual problem.

An advantage of differentiating between immediate and deeper causes is that this clarification enables the clinician to deal with a multiply-determined sexual dysfunction in a sequential or stepwise manner, as outlined in the work of Kaplan or within Annon's PLISSIT model, which prescribes the sequential use of: permission, limited information, specific suggestions, and intensive therapy (Annon, 1974, 1975; Kaplan, 1974b, 1979). The order of intervention in these stepwise approaches is to first address immediate causes, and where this proves ineffective or insufficient, to escalate to more intensive therapy, including examination of deeper aetiological and maintaining factors. Another advantage of the immediate- and deeper- causes model, as one interviewee stresses, is that it may enable the clinician to deal with aetiological factors across the individual's life course,

> more on a spectrum than in a dichotomous way. So that the aetiology of a dysfunction for a person can come from something in the here and now, in their current relationship and stresses they're experiencing, whether it has to do with the relationship or not. It could have to do with a previous relationship in their adult life, it could have to do with an abusive situation

> anytime in their life, it could have to do with modelling by their parents when they were young—and I always ask about their family background. And of course there can be medical issues…. So, it's really a range of things that I look for, and it can be not only a range in terms of time, but it can be a range in terms of how physical, versus psychological, versus relational it is (Plaut, research interview, 17/01/2013, transcript p. 4, lines 1-14).

As Plaut emphasizes here, the psychological and relational aspects of sexual problems are highly variable and must be assessed in relation to the individual's life course and sexual history. In fact, one of the salient findings in the data, with respect to causation, is the importance of factors across the life's span, including early life experiences.

8.2.1. The Importance of Early Life and Developmental Experiences: Qualitative Interview Results

Clinicians' tendency to focus on the client's early life was amongst the most prominent themes in the qualitative data, with 70.6% of interviewees emphasizing the clinical significance of early life and developmental experiences, in particular their influence on current relationships and sexual functioning. A high number (64.7%) of interviewees also indicated focusing on the client's family of origin in assessment and treatment. The specific use of a developmental focus, and focusing on how the client's early life parental relationships influence the client's current sexuality, were also identified as specific sub-themes in the qualitative data.

Here, data indicate that these techniques, which entail close examination of early life experiences, are seen as clinically important by psychodynamic psychotherapists and non-psychodynamic practitioners alike. McCarthy, for instance, states that,

> for me, there isn't a psychodynamic bone in my body. What I think is important, though, in terms of the translation, is understanding the different experiences and meanings of sexuality that people have. Whether it's from the culture, from their family, from childhood sexual trauma. So…instead of using a psychodynamic model, my model is more the model of processing your experiences, in terms of healthy learnings, and in terms of poisonous learnings (research interview, 17/01/2013, transcript p. 4, lines 27-34).

While McCarthy works within a self-consciously non-psychodynamic treatment orientation, this insight may be relevant across modalities for practitioners seeking to

conceptualize early and prior life experiences, including practitioners who explicitly integrate psychodynamic techniques and principles in their practice.

For many sexually dysfunctional clients, early life experiences (i.e. poisonous learnings) are seen to produce persistent patterns of guilt, shame and anxiety associated with sex and sexual behaviour, which are highly prevalent themes in the qualitative data, and appear to be a particularly important psychoaffective pattern for many clients. The role of guilt as an aetiological/influential factor in sexual functioning is identified by 20.6% of interviewees (17.6% explicitly), while 26.5% of interviewees (20.6% explicitly) emphasize shame as a causal factor. In fact, the data indicate that shame may be so endemic to sexuality and sexual problems that many sexual therapy clients have a sense of discomfort (especially shame or a sense of stigma) about discussing sexual issues with their therapist, a trend that is believed to adversely affect the treatment process. Anxiety, a predictor of dysfunction commonly accepted in the clinical and research literature, also holds a prominent place in the data collected in this study, as a high proportion (50.0%) of interviewees emphasize anxiety as a core causal/contributing factor in clients' sexual problems (Bruce & Barlow, 1990; Laumann et al., 1999; Laurent & Simons, 2009).

A number of interviewees stress that the linked experience of guilt, shame and anxiety—addressed at greater length in section 8.5, below—is an almost universal contributor to sexual dysfunction, and is largely established through psychosocial experiences throughout the life's course, including childhood and infancy. Thus, the apparently pervasive aetiological role of guilt and shame—viewed as developmental outcomes of early and ongoing life events—in clients' sexual problems underscores the importance of socio-cultural factors, and socialization experiences in the individual's psychosexual development. This finding is supported by the prominence of social and cultural aetiological factors within the qualitative data, as half of the interviewees in this research project emphasize cultural factors' influence on sex and sexual functioning.

Kirkpatrick, for instance, suggests that gendered socialization experiences are inbuilt within the scripts of sexual behaviour that influence clients' experience of sexual dysfunction. "There's a whole lot of stuff," he states, "around—particularly for men—the sort of socialization and learning and what people learn about sex roles and gender roles…men get very uptight sometimes about, particularly, things like erection problems" (Kirkpatrick, research interview, 17/01/2013, transcript p. 4, lines 25-28). This emphasis on gendered socio-cultural factors appears to support the use

of a social constructionist framework in working with clients' sexual problems, and a number of clinicians suggest that social constructionism may be used both to help the therapist interpret the male client's sexual difficulties, but also as a therapeutic device, to help the client himself understand and address the sexual problem within a social and systemic framework. Kirkpatrick proceeds to recommend a clinical strategy based on this interpretation; "when I first see a client," he states,

> I would say to them that when we're born we don't know anything about sex or about relationships. And so everything that each individual thinks, feels, believes today is based on all sorts of things that have gone on around them, things they've heard, things they've witnessed, things they've interpreted as they've grown up. And we then usually spend one session…going over their life history to try and identify what their particular story is. And then if you're working with a couple, you would obviously do that with both partners, and put the whole lot together, and sort of use that to make sense of what it is they've learned, what it is they've assumed, what it is their expectations and their blueprints are based on (research interview, 17/01/2013, transcript p. 4, lines 39-46, p. 5, lines 1-2).

This technique illustrates two aspects of clinical intervention that are significant in the data: the importance of early life experience in determining clients' sexual and relational schemas, (in Kirkpatrick's terms, the "blueprints" for relationships and sex), and the clinical value of helping foster client insight into these processes (Cyranowski & Andersen, 1998; Stephan & Bachman, 1999).

From a sociological vantage point, the data suggest that clinicians see Western society as non-neutral on sex, and the idea that 'sex-negative' messages are pervasive in Western culture is a prominent sub-theme in the qualitative data. For some interviewees, this sex-negative orientation is evident in culturally-specific relationship schemas (the conceptions of relationships and sexual behaviour that are reflected in the client's culture), and even in "the language people use in [speaking about] sexuality," which serve to shape the client's experience of sexuality (Cass, research interview, 03/02/2013, transcript p. 15, line 24). Data indicate that the manifestation of this sex-negative schematization of sexuality often assumes the form of linear and narrowly prescribed sexual behaviour sets, which link sex to heterosexuality, monogamy, and a performance-oriented model well documented in the literature (Berry & Barker, forthcoming 2015). The narrow delimitation of culturally approved sexuality is seen as one of the manifestations of this perceived

sex-negative attitude, and as a significant contributing factor in clients' sexual difficulties.

The qualitative data suggest that sex-negative messages (and/or messages about the narrowly defined boundaries of permissible sexuality) are internalized by the client, and exert an unconscious and often repressive influence over the client's sexuality. In addition, the data strongly suggest that this sex-negative framework contributes to the aforementioned development of guilt, shame and anxiety associated with sex and sexuality. It is possible, then, that negative affect and cognition—in particular guilt/shame/anxiety—may become profoundly linked with sex, although this link may remain unrecognized, or unmentalized, and may function largely as an unconscious process.

Several other sub-themes in the data are linked to the perception of sex-negative and restrictive conceptualizations about sex in Western culture. A number (23.5%) of interviewees emphasize the influence of sexually restrictive cultural factors, while some (14.7%) stress that sexual difference/non-conformity is often equated with pathology in Western culture. Ogden illustrates these sub-themes, putting emphasis on the divergence between the individual's underlying desire and manifest desire, and stressing that the latter is influenced by socialization experiences. "The first question," she states, is,

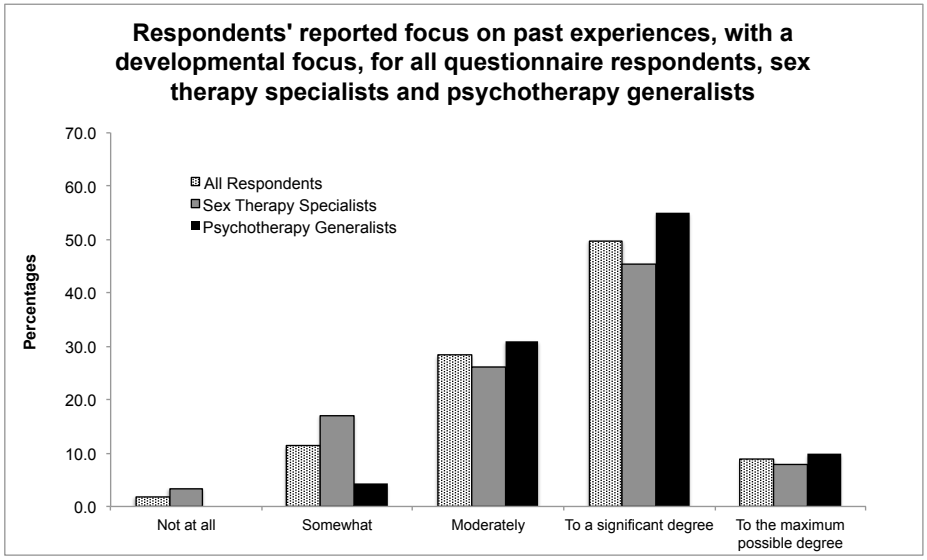
> desire is desire for what? Is it desire for face-to-face intercourse in the dark, and marriage for the procreation of children, man on top? Or is it desire for something else, something more? And, so that really is the first question…Why we're, most of us, cut off from our desires for sex…is that we're terrified, and we're usually terrified because something bad has happened to us, very often at an age before we had any kind of control…[it can come from a wide variety of experiences,] but it's that 'no' or that 'stop' comes at a time that you become frozen in time (Ogden, research interview, 08/11/2012, transcript p. 3, lines 14-29).

From this perspective, the repressive function of early life experiences is seen to have an enduring, and pervasively damaging, effect on the individual's sexuality, potentially predisposing the individual to sexual problems in adulthood.

8.2.2. The Importance of Early Life and Developmental Experiences: Questionnaire Results

The conception that sexual problems are strongly predisposed by early life experiences, in particular prohibitive or anti-sexual socialization experiences, leads to a clear assertion of: 1) the importance of childhood and infancy as developmental stages in healthy/unhealthy sexuality, and 2) the need to focus on the client's developmental history as a treatment strategy. Figure 8.1 indicates questionnaire respondents' answers to the question: "in the most recent case of male sexual dysfunction you treated, to what extent did you discuss the patient's past experiences (especially with a developmental focus)?"—a technique that Jones and Ablon classify as prototypical of psychodynamic psychotherapy— measured on a Likert scale ranging from 1—'not at all' to 5—'to the maximum possible degree'. (Ablon & Jones, 1998; Ablon et al., 2006)(see also tables 6.4 and 6.5 above, and table 9.1 and figure 9.4, below). An independent sample t-test was performed, which demonstrated that psychotherapy generalists ($M = 3.7$), report focusing on past experiences, with a developmental focus, to a somewhat greater degree than sex therapy specialists ($M = 3.4$), with their most recent relevant male patient/client $t(157) = 2.386$, $p = .018$.

Figure 8.1 Respondents' reported focus on past experiences, with a developmental focus, for all questionnaire respondents, sex therapy specialists and psychotherapy generalists



Overall, a majority of both sex therapists (53.41%) and psychotherapy generalists (64.79%) report using this technique to a significant degree or to the maximum possible degree. This finding accords with the high level of focus in the qualitative

data on developmental processes, including sexual aspects of infancy and early childhood, as aetiological components in the client's sexual difficulties.

8.2.3. The Importance of Early Life and Developmental Experiences: Discussion of Results

The client's family of origin experiences are an especially prominent consideration in both the qualitative and quantitative data, and appear to be an important focus for many psychosexual therapists (as addressed here, and in chapter 6). This emphasis on early life experiences and parental influence over the development of the individual's sexuality may in part reflect the significant influence of attachment theory over the current field of psychosexual therapy, and the enduring influence of psychodynamic theories of early repression of child sexuality (Stefanou & McCabe, 2012).

The view that infantile and childhood sexuality is a key variable in later life sexuality, and attachment style (discussed at greater length below, especially chapter 9), is evident. For a number of clinicians interviewed, it appears that "child sexuality," as Seabloom states, is seen as "the foundation. Child sexual health is the foundation for adult sexual health. It all comes out of the child" (research interview, 13/01/2013, transcript p. 4, lines 17-19). Thus, in both the wider literature and in the data from this study, prohibition of sexual behaviour in early life is seen as a powerful determinant in the client's difficulty, or inability, to integrate sexuality within his psychosocial and relational schemas in adult life (Fonagy, 2008a; Resnick, 2012; Target, 2007).

It appears to be widely accepted amongst research participants and leading psychodynamic researchers that sexual desire and masturbatory behaviour are natural amongst children and infants (a view that Freud promoted strongly), but that these behaviours are routinely forbidden by parents and caregivers, with enduring psychosexual consequences. According to Savage,

> when [children and infants] are not frightened or traumatized into suppressing these normal impulses, they learn acceptance of sexual pleasure. Most children [however] are taught to repress sexual feelings using mechanisms of shame or guilt. Once repressed, sexuality goes underground until all the powerful hormones of adolescence overwhelm these shame mechanisms (2004, Chapter 6, Section 1, para. 5).

The enduring effects of these early life experiences highlight the importance of a developmental focus in the work of psychotherapists treating male sexual dysfunction—a prominent theme in the research data. Consequently, as indicated above, the data from this study reveal a broadly critical view of the ways in which children are taught about, and socialized into, sexuality in Western society.

Consistent with this critical view, a wide cross-section of sex therapy specialists surveyed appear to concur with Openshaw's assertion that "we need to develop people all the way up from very young developmental stages through, so they can be adults out there having sexual contact with each other" (research interview, 26/02/2013, transcript p. 9, lines 34-36). It appears that early intervention—which is to say early life intervention—at the level of social conditioning and psychoeducation, is seen by many sex therapists as a theoretical ideal. However, it is acknowledged that the treatment for many adult clients entails works with developmental material retrospectively. Evidence suggests that, in this retrospective work, a substantial proportion of sex therapists continue to use the predisposing-precipitating-perpetuating model of assessment and case formulation, discussed above (chapter 6), to evaluate the developmental factors that underlie sexual and attachment processes—both conscious and unconscious—in the client. This developmental model may offer a means for understanding early life experience according to McCarthy's framework identified above: in terms of healthy versus poisonous learnings, and in terms of the internalization of healthy versus unhealthy schemas around sexual and relational behaviour.

As discussed in chapter 5, the inclusion of the partner—where there is one—in the assessment and treatment process, reflects a relational, psychosocial orientation to the treatment process in which the sexual problem is seen as inherently situated within a relationship context (McCabe, 2001; McCabe et al., 2010; McCarthy & Thestrup, 2009a). Similarly, the developmental focus, implicates a focus on the development of attachment patterns and inner working models of sexual and intimate relationships (Johnson & Zuccarini, 2010). Levine posits a theory that may help distinguish between: 1) problematic developmental factors which affect the individual's conceptions of sex and sexuality in early life, and 2) issues within the current relationship that may foster or perpetuate sexual problems. Sex therapists, he suggests, may often,

> have a sense that…psychologically impaired sexual dysfunction stems from one's development as a person and one's sensibilities about what sex is, and

> the anxieties that one is not going to be good enough for it, to achieve those goals. Or it comes from nuanced complexities in a relationship, during which the sex has faltered (research interview, 08/01/2013, transcript p. 1, lines 28-34).

A discretionary choice is then made—to focus on current relational factors, or to give precedence to developmental material. In either case, the implication of this theory is that psychogenic sexual dysfunction is largely the outcome of both developmental psychological and relational processes, which can be conceived according to the biopsychosocial model.

An especially important theme in the data is the apparently widespread belief that the client associates a psychological and relational "meaning" to sexuality and to sexual acts (see tables 8.1 and 8.2). Consequently, exploration of the meaning (or perhaps more appropriately, "meanings") sex and sexuality hold for the client, is an important sub-theme within the qualitative data, and interviewees hold that examination of these frameworks of meaning is crucial to successful therapy. To extrapolate into a psychodynamic framework, these data suggest that healthy and unhealthy (i.e. "poisonous") learning experiences may influence the meanings an individual associates with sex and sexuality both consciously and unconsciously. Therefore, a clinician may work to help the client process these experiences in terms of healthy and unhealthy learnings, at both an immediate and deeper level, with attention to both conscious and unconscious factors, a process discussed at greater length in chapter 9.

In these respects, attention to early life and developmental factors is seen as essential within the research data. The concept of "meaning" expands beyond classic behavioural exercises, and entails helping the client to gain new insight into the causal factors underlying the sexual problem, including early life factors that may influence the client at a deeper, unconscious level (Kaplan, 1974b; Plaut et al., 2004). As will be addressed below (section 8.8), interview data indicate the importance of unconscious intentionality in shaping the sexual symptomatology. Here, however, it is important to further explore the socio-cultural roots of sexual problems as they are defined in the data—in particular, the unforeseen apparent influence of religious experiences.

8.3. Aetiology: The Role of Religion

Religious upbringing was cited as a pivotal aetiological factor in male sexual dysfunction by a significant number (41.4%) of interviewees. This unanticipated finding is noteworthy for two reasons: 1) the high level of emphasis on religious socialization's significance as a causal variable, and 2) the fact that religion was not, in itself, a point of inquiry in the survey (i.e. none of the interview questions focused on religion or religious factors specifically, and religion was brought up spontaneously by interviewees in response to more general questions about their perception of the aetiology of sexual dysfunction). The level of focus that participants place on religion implies that it may be a particularly important element in the context of sex therapy work.

While a critical view of religion was predominant in the research interviews, the consensus view was not a scoping indictment of religion, or religious observance per se. Rather, a majority of interviewees expressed a critical view of the repressive function of certain types of religious socialization, and certain sexual mores—specifically high levels of sexual restriction, or sexual conservatism—seen to be embedded in some clients' religious upbringings. The following interview dialogue illustrates this prevalent view:

> Seavey: some [clients] have very, you know, sort of I would characterize it as *repressive* religious upbringings, that can affect things. "Sex is a bad thing," you know, like that.
>
> Berry: Absolutely. And how would you go about dealing with that?
>
> Seavey: Well, I would talk to them about it a lot. "Why do you think this" and you know [they reply], "well, my mother told me this". Ok "well, how accurate do you think your mother was about this?" Like that.
>
> Berry: And is it fair to say that they have—is it a repressive type of upbringing?
>
> Seavey: Well, it depends what you consider repressive. Let me put it this way: the tenets of their religious psychosocial environment seems to be not at all accepting of lots of common sexual practices. Let me put it that way (research interview, 01/02/2013, transcript p. 7, lines 1-16).

These types of religious upbringing, some interviewees argue, promote a restrictive view of allowable sexuality, which is seen to have powerful implications for the client's sexuality, and specifically for the meanings the client associates with sexual behaviour.

Several aspects of religious experience in early life are seen to have a significant negative impact on sexual functioning. First, there is a broad sense that, in certain religious traditions, sex in general is stigmatized; Gutteridge describes this as a function of underlying "religious beliefs, where sex can too easily be seen as dirty or not acceptable" (research interview, 23/01/2013, transcript p. 9, line 4). Additionally, a number of interviewees view religious ideologies as defining a narrow margin of permissible sexuality—for instance, in the form of monogamous heterosexual sex, sanctioned by marriage. By implication, non-conforming sexual identities and behaviours are condemned, making it difficult for clients to integrate divergent sexual elements into their sexual schemas and sexual identities. The primary emphasis is on religious experience as a repressive force that restricts the individual's sexuality and cultivates guilt, anxiety, and shame. Clulow and Boerma provide a description of religion's repressive function in the Judeo-Christian tradition, which reflects a perspective that a number of research participants in this study appear to share. "The history of religion," they write,

> is marked by the repression of sexuality, leaving in its trail a legacy of guilt and shame. In this context, the institution of marriage acts, in the words of the 1666 Book of Common Prayer, as 'a remedy against sin'; as St Paul puts it in his letter to the Ephesians, 'better to marry than to burn' (Clulow & Boerma, 2009, p. 77).

Interview data illustrate that, in addition to a Western, Christian context, clinicians observe a similar impact in other religious cultures that closely guard sexuality, condemn sexual diversity, and hold marriage as an imperative criterion of acceptable sexual conduct.

However, two interviewees, Ravella (2013) and Seabloom (2013), also point out the risks of taking an overly critical or condemnatory view of religion as an aetiological factor in clients' sexual problems, a perspective that accords with extant research on the correlation between psychotherapist expectation and psychotherapy outcome. Research suggests that where a psychotherapist holds a low expectation of therapy success, this expectation itself may have a negative impact on the therapy outcome (Ackerman & Hilsenroth, 2003; Daines & Perrett, 2000, p. 118; Sandell et al., 2007). Consequently, a psychotherapist's assumption that a client's religious background will negatively influence sexual functioning, or sexual satisfaction, may in itself reduce the likelihood of therapy success; thus, Ravella states, while religion is a focal topic for sex therapists, it is important that therapists not presume a priori

that it will be an inhibiting factor in the client's sexuality (research interview, 11/01/2013).

Additionally, a number of therapists describe experiences working successfully with specific religious populations, and suggest that incorporating the client's religious beliefs into the therapy process may often be a powerful tool for psychotherapeutic change. Dunn, for instance, recommends involving religious leaders, where relevant, in the treatment of sexual problems, particularly by including them within the referral network. She states,

> I've learned over the years that sometimes it's useful to have religious leaders you can refer to, because I find people often hide behind their religion. They're sort of misinformed on what their religious guidelines really are (Dunn, research interview, 29/01/2013, transcript p. 9, lines 2-4).

Dunn and others therefore suggest that the influence of a religious or spiritual leader can have a powerful therapeutic effect on religious clients, and may be used to positive effect; it is believed that client consultation with a religious leader may serve a psychoeducational function, and help counteract anxiety, guilt, and shame, which are seen as mediators of religious beliefs' effect on sexual problems.

Relatedly, emphasis on the spiritual aspects of sexuality is a sub-theme within the qualitative data, as a number of interviewees emphasize that some clients may associate sexuality and sexual behaviour with spirituality. Published research, and the data from this study suggest that, for such clients, spiritual discourse may serve as a therapeutic tool, with a spiritual conception of sexuality being seen by the therapist as a potentially enriching aspect of the sexual experience (Helmeke & Bischof, 2007; Ogden, 2001, 2006, 2008; Savage, 1999; Ullery, 2004).

8.4. Aetiology: The Roles of Anxiety, Guilt and Shame

As stated above, a high proportion of research participants emphasize three key factors—anxiety, guilt and shame —which may variously act as predisposing, precipitating, or maintaining factors in clients' sexual problems. Published research indicates that these aspects may be linked to experiences within a current relationship, or previous/early life experiences, including:

- conditioning/socializing influences (including religious upbringing), both within the family of origin, and amongst friends and other informal social groups (Shtarkshall, Santelli, & Hirsch, 2007; Simpson & Ramberg, 1992),

- socialization experiences in particular social institutions, including school, a religious institution, or other formal social groups etc. (Jones, Meneses da Silva, & Soloski, 2011), or
- the wider society/culture, including popular media (Althof et al., 2005; Rubio-Aurioles & Bivalacqua, 2013).

In effect, evidence suggests the internalization of psychoaffective anxiety, guilt, and shame may be fostered in any facet of the individual's social life, throughout the life course.[33] Fundamental restrictions on sexual behaviour, linked to early socialization experiences, and persistent norms and mores that delineate the limits of sexuality, are salient within the data. A quote from one interview eloquently captures this pervasive view; from early life, Savage states, "shame gets paired with sexual desire" (research interview, 04/11/2012, transcript p. 15, line 44).

As the following sections discuss, from a psychodynamic vantage point, anxiety, guilt and shame, may be seen as core unconscious processes, intimately linked to sexuality through early life experiences, in particular repression and suppression, in the family of origin, (Brenner, 1957; Freud, 1961h; Gabbard, 2005; Gabbard et al., 2012). While no evidence of a classic psychoanalytic conception of psychosexual repression and neurotic illness was found in the data from this study, the findings presented in the following sections suggest that an implicitly psychodynamic conception—which links sexual problems aetiologically to shame, anxiety, and guilt, and to repressive processes and socialization experiences—may be common amongst psychosexual therapists.

8.4.1. Aetiology: The Role of Anxiety

Interpreted within a psychodynamic framework, it may be theorized that close regulation of sexual behaviour imposes significant restriction on the sexual drive, from early life onwards (Fonagy, 2008a; Freud, 1961h). As discussed above, data from this study indicate that this regulation of sexual desire and libido comes through both direct and explicit rules governing behaviour, and more implicit, internalized social scripts that serve to condition the client's subjective experience of sex and sexuality. Consequently, for many clients, high baseline anxiety about sex—largely due to pervasive, and restrictive, cultural expectations/pressures—may

[33] It is important to note that, alongside potentially inhibiting social influences (i.e. those that foster anxiety, guilt or shame), interviewees also emphasize the importance of considering positive social influences (see tables 6.2 and 6.3), for instance the factors that contribute to the "healthy learnings" emphasized by McCarthy (research interview, 17/01/2013).

predispose, precipitate, or maintain sexual problems. Latent sexual anxiety—particularly when coupled with a disappointing or upsetting sexual experience—may evolve into an acute and debilitating performance anxiety, a process long recognized within behavioural streams of sexology and sex therapy, including the work of Masters and Johnson (Barlow, 1986; Masters & Johnson, 1966; Masters & Johnson, 1970).

Qualitative data suggest that two conceptually distinct, but functionally overlapping, areas of anxious ideation and affect may be distinguished:

1) direct anxiety about sex or sexual issues, and
2) anxiety about non-sexual issues, which impacts on sex and sexual functioning.

In the former category, anxiety about sex is seen to include anxiety about one's own sexual normality/abnormality—an aspect that may often link closely to experiences of guilt and shame, and linked ideational processes—or, as has been widely documented in the research literature, anxiety about sexual functioning and sexual performance (Lopiccolo, 1994; McCabe, 2005; Telch & Pujols, 2013). There is, according to Barker, "an ever-increasing anxiety about sex, and a concern about being unable to have functional sex" (Barker, 2011a, p. 33). Barker describes the cognitive (and physiological) processes linked to performance anxiety for many clients, stating,

> in sex: you're struggling, you know, to get an orgasm, you start getting anxious about 'am I going to get an orgasm or not'—you are *never* going to get an orgasm. You know? But mindfulness—this idea of being present—would be the counter to that…it's just about being in the moment, really, of whatever you're doing. And paradoxically orgasm is a lot more likely under such conditions (research interview, 30/03/2012, transcript p. 21, lines 37-40, p. 22, lines 3-5).

Prior research also suggests that, (as discussed in chapter 7) in many cases, anxiety about sexual functioning may be linked to a performance-focused orientation to sex, and often to the experience of a performance-demand, against which 'successful' sex is assessed (Berry & Berry, 2014; McCarthy & McCarthy, 2013; Rowland et al., 2011). Where sexual dysfunction or difficulty endures across time, an anxiety-informed sexual script may develop, in which sexual dysfunction is anticipated prior to sexual behaviour, and emerges in a predictable pattern. In such cases it is possible

that performance anxiety and a script of sexual disappointment serve to perpetuate the sexual dysfunction.

Additionally, interview data suggest that some couples may experience a long period of sexual inactivity, or significantly limited sexual activity, due to sexual dysfunction or other relationship factors, a finding consonant with existing research and recent clinical guidelines (Bulow, 2009; Donnelly, 1993). In such cases, the possible resumption of sexual activity may in itself be anxiety-provoking, and may dispose either member of the couple to sexual dysfunction or sexual disappointment. Dunn also indicates a related, ostensively counter-intuitive, anxiety that may affect some clients: anxiety or fear of *success*. For many people, she suggests,

> the known evil is better than the unknown good. People are afraid of change. And the status quo is more secure, so change in itself is threatening to the integrity of a couple or individual. So that's one sort of resistance. The other is…I will ask couples at the beginning: what bad things could happen if this sexual problem disappears? And you get a spontaneous reaction. Sometimes you get: "oh, he'd want sex all the time, if he could have erections" or "I'd have no control over the situation" or "…if she learned to have orgasms, I wouldn't be enough for her. She might want to be with other men (Dunn, research interview, 29/01/2013, transcript p. 4, lines 34-43).

For many clients, in Dunn's view, a wide range of related anxieties are associated with the possible elimination of the sexual dysfunction, which may contribute to resistances to the treatment course.

It is important to note that, as a causal factor in the sexual dysfunction, anxiety may operate beneath the client's awareness. Qualitative data suggest that anxiety may be unconscious or simply unrecognized (unmentalized). This distinction appears to align generally with the distinction between *unconscious* and *preconscious* psychological factors (see especially section 6.6.4., above). However, it is important to note that, according to research evidence in this study, misattribution of anxiety (i.e. attributing sexual anxiety to non-sexual factors, or confusing the relative contributions of sexual and non-sexual elements in the anxiety associated with sex) may be prevalent for sex therapy clients. Further research evidently is needed to determine how/why anxiety may remain unmentalized in male sexual dysfunction clients specifically, and how anxiety driven by different (esp. sexual and non-sexual) sources may interact.

As intimated above, data from this study also suggest it is possible that the client may be aware of his affective experience of anxiety, but unaware of the origin of the anxious process or associated ideational content. As Resnick states,

> it could be old anxiety, so that there may not even be awareness of where that anxiety comes from. That's what I call autonomous. An autonomous emotion, where you don't have any—you can't identify where it's coming from, but it is almost like a classically-conditioned response to a sexual situation (research interview, 04/11/2012, transcript p. 5, lines 34-37).

Qualitative data and existing published research suggest that as the therapist works to help the client identify anxiety and discern the origins of anxiety-based patterns in cognition, affect, and behaviour, it may be necessary to examine both immediate and deeper contributing factors, which may be conscious or unconscious (Bartlik, Rosenfeld, & Beaton, 2005; Perelman, 2006b; Plaut et al., 2004).

Study data also indicate that some sex therapists place a high level of importance on the biological vector of anxiety, pointing to stress, physiological arousal, and physiological stress-responses associated with anxiety as important contributors to sexual problems. In this respect, the data support the view that it may be important to evaluate stress effects produced within the relationship, or outside, in the environmental context, Savage stresses this point, writing,

> a highly stressful environment can create anxiety-based loss of desire. Anxiety is sustained fear that keeps our fight-flight response operating past the initial crisis…[and] the source of the fear may not even be in our conscious awareness (2004, Chapter 1, Section 4, para. 1).

Situational stress in the non-sexual facets of the client's life is indicated as common. Interviewees suggest that outside life factors, including stressful elements in the client's professional life, and non-sexual personal relationships are widespread contributing factors in the client's sexual problems. Stress in the client's wider life, then, may function as a predisposing or perpetuating factor in the sexual problem, as well as a physiological precipitant. At the level of intervention, interview data indicate that helping the client to understand, address and attenuate the influence of stress and stress-induced anxiety may necessitate behavioural interventions and strategies to reduce stressors, or implementation of more effective stress management strategies outside the bedroom.

8.4.2. Aetiology: The Roles of Guilt and Shame

Alongside anxiety, guilt and shame are widely seen as commonplace elements in the aetiology of sexual problems. Hall, who specializes in treating out of control sexual behaviour, differentiates between guilt—which is seen as behaviourally focused—and shame—which is focused on the individual's self (2011; research interview, 18/04/2012) . Shaming, she holds, is routinely used as a behavioural control tool, by parents and caregivers, in the child's early life, with enduring sexual effects. She states,

> often shame is used by parents as a punishment, as a method of control…And I think when someone is brought up being used to having a sense of low self-esteem because of their behaviour, it is easy. Sex can trigger shame in us anyway. That seems to be, anthropologically, everywhere you look. We have sex in private. We're the only animal that has to have sex in private. Shame seems to be around. Embarrassment, whatever. So if you've already got a predisposition set up about shame, when you start experiencing sex and sexual thoughts, then it's likely to be even worse. So your shame button is already going to be pretty huge and pretty sensitive because of the childhood stuff. In terms of overcoming. Pretty much any model of therapy is going to allow someone to look back with their adult hat, their adult head, on, at what happened in the past and consider, 'is that really something that as a six year old, ten year old, fourteen year old, whatever, you should have felt ashamed by?' (research interview, 18/04/2012, transcript p. 5, lines 6-20).

Data suggest that for some therapists, as with anxiety, drawing the client's critical attention to the immediate and deeper effects of guilt and shame is an important therapeutic technique. Even clients who have a sense *that* some combination of anxiety, guilt and shame is a factor in their sexual problems may often have significant difficulty understanding the roots of these processes. Psychodynamic theory suggests that guilt and shame, and their underlying causes are often largely beyond the bounds of the client's explicit awareness, and that, consequently, it is useful to consider them as partially unconscious or preconscious factors (Gabbard, 2005). Additionally, the complexity and ethical/moral underpinnings of guilt and shame suggest that they may often have a significant unconscious dimension, rooted in repressive experiences, particularly in early life, and throughout childhood and adolescence.

The psychoanalytic concepts of neurosis and repression may be useful in conceptualizing the unconscious processes associated with sexual guilt, shame, and anxiety. Sexual repression and denial of sexual urges are, in traditional psychoanalysis, at the heart of mental illness. "For most people," Freud writes,

> there is a limit beyond which their constitution cannot comply with the demands of civilization. All who wish to be more noble-minded than their constitution allows fall victims to neurosis; they would have been more healthy if it could have been possible for them to be less good (Freud, 1961b, p. 191).

As Gabbard writes, in Freudian terms, repression was viewed as the "queen of all defenses. It operates unconsciously by expelling unacceptable wishes, feelings, or fantasies from conscious awareness" (Gabbard, 2005, p. 30). Thus, repression serves as the intrapsychic mechanism by which sexual thoughts, feelings, and desires—stifled by guilt and shame—are controlled.

Yet, it has been suggested that the function of repression may best be seen on a continuum of mental health. As Seymour states, "we do need repression of some sort, otherwise we would all walk down the street and be stark naked, and so on, so we have to repress" (research interview, 04/07/2013, transcript p. 9, lines 18-19). This view of repression as a necessary process was also clearly expressed in Freud's work (Freud, 1961a), and is seen as linked to the process of suppression—which has been classified as a "healthier" or more "mature" defensive process (Gabbard, 2005; Vaillant, 1977). Whereas repression is considered an unconscious process, suppression is defined as the "*conscious*…banishing of unacceptable thoughts or feelings" (Gabbard, 2005, pp. 31-32). Thus, data here suggest that psychodynamically-oriented therapists surveyed view both repression and suppression as psychosocially necessary processes, which carry adverse effects—for instance, the production and maintenance of shame, guilt and anxiety, and the risk of neurotic symptoms.

In fact, for Freud—who coined the phrase "anxiety neurosis"—neurotic illness was profoundly linked to anxiety, largely a consequence of repressed thoughts or desires that could be addressed through psychotherapy (Freud, 1961c, 1961e). In traditional psychoanalytic thought, neurosis was the core of a variety of psychopathologies, which were linked to internal conflict (i.e. between the libido and

the prohibitive injunctions of the superego[34]). Although there is no evidence in this study that contemporary psychosexual therapists subscribe to a classic psychoanalytic model of neurotic mental illness, there is evidence that repression, suppression, and the internalization of a harsh or condemning parental voice, are seen as important processes in the development and treatment of sexual problems, and that these processes are often linked to anxiety, guilt and shame. This conceptualization of sexuality appears to agree with a psychodynamic concept of repression, and influence of restrictive early socialization experiences and parental influence. "At the most mature level," Gabbard writes, "anxiety originating in the superego can be understood as guilt feelings or pangs of conscience about not living up to an internal standard of moral behavior" (Gabbard, 2005, p. 234).

Overall, the idea that the individual is subject to repressive forces—through socialization experiences and prevalent social attitudes about sex and sexuality—appears to be a key theme in this research, regarding the aetiology of male sexual dysfunction. In fact, 26.5% of interviewees implicitly or explicitly identify repression or repressive processes as a contributing element in clients' sexual problems. While none of the psychosexual specialists interviewed for this research project used the language of neurosis specifically, and no external evidence that a psychoanalytic concept of neurotic illness is a widespread element in contemporary sex therapy practice was found, a substantial proportion of clinicians interviewed emphasize the cultural sanctioning of sexuality, and the internalization of restrictive margins of permissible sexual behaviour as key elements in many clients' sexual problems. When asked about the key contributing factors in male sexual dysfunction, Barker replied, "restricted societal ideas about: 'what is sex?'—would be number one. There's a load of other stuff…but that's my number one" (research interview, 30/03/2012, transcript p. 27, lines 6-7). Another interviewee in effect paraphrases Freud's position on the social and cultural repression and limitation of sexual behaviour, stating:

> It just depends on what culture you're in. You're going to understand through the shaming process that some expressions of sexuality are not good…sexuality, on some level, is curtailed. And I think many of us humans,

[34] As Higdon writes, the superego is conceptualized as a "mostly unconscious" psychological structure, which "contains all the strictures from our youth. Parental voices are there in abundance, in particular a harsh, punitive voice…this is the voice that chides the client, making him feel guilty" (2012, p. 47)

> we wish to live in a society where sexuality was less curtailed (Milrod, research interview, 11/10/2012, transcript p. 20, lines 12-17).

Thus, as stated above, evidence from this research suggests that a psychodynamic concept of repression—as a contributing factor in sexual dysfunction, and an element that may serve to instil guilt and shame—may be of use to sex therapists, and may in fact be implicitly present in sex therapy discourse.

It is important to note, however, that while a psychodynamic concept of repression may underlie sex therapy work in many cases, and may serve to enrich sex therapy theory and practice, there is a significant point of divergence between psychodynamic psychotherapy (particularly more traditional or classical streams of psychoanalytic and psychodynamic psychotherapy) and contemporary sex therapy, in their respective orientations to working with repression, anxiety, guilt and shame. In particular, these two clinical specializations appear to differ substantially in their attention to the range of mental experiences and psychological concerns attributed to repressive processes. Whereas psychodynamic psychotherapy aims to treat a vast range of issues, under the broader banner of sexual repression (as illustrated in Kahr's conceptualization, quoted in chapter 5, of "disorders of the self"), it appears that sex therapy is often ultimately focused on the client's sexual and relational experience, seeking to contextualize the client's guilt, and shame—and past repressive experiences—in relation to these factors specifically.

While further research is needed to determine how psychodynamic theory could explicitly be integrated within sex therapy to account for the influence of guilt and shame in men's sexual problems, as discussed above, the qualitative data in this survey appear to support the hypothesis that an implicit theory of sexual repression is present in the work of many psychosexual therapists. By virtue of the pervasiveness and apparently significant psychological impact of "restricted societal ideas about" sexuality, data suggest that the experience of guilt and shame for many clients is profound and pervasive. Openshaw, for instance, indicates that a particularly important consideration,

> from a psychodynamic point…is shame, and how you work with the internalized shame and that sort of core sense of self that is often present in terms of memory, and present in body, and in all sorts of ways for people when talking about sexual problems (research interview, 26/02/2013, transcript p. 9, line 22-25).

This quote highlights the fact that, in addition to emphasizing the impact of guilt, shame and anxiety over thought and behaviour, data indicate the importance of the biological vector of the biopsychosocial model, particularly the role of the body and embodiment as they link to these psychoaffective factors, and to sexual difficulties.

8.4.3. The Role of Embodiment in Anxiety, Guilt and Shame

A number of interviewees (17.6%) emphasize the client's experience of sexual embodiment as a key consideration for psychotherapists and sex therapists (see tables 5.2 and 5.3, appendices I and J). It is asserted that sexually inhibiting emotions and thought processes—including anxiety, guilt and shame—strongly affect the individual's body, and may contribute to persistent physiological reactions that impede the client from sexual functioning and/or sexual satisfaction (Resnick, 2012; Resnick, research interview, 04/11/2012) . Additionally, the ways in which the client conceives of his body, and associated feelings of shame, anxiety, or like emotions, are seen to affect the client's sexual experience (Britton, research interview, 23/02/2012). In short, anxiety, guilt and shame are seen as experienced both *in* the body and *about* the body, two facets of concern in the interaction between the biopsychosocial domains.

The qualitative data suggest that the embodied experience of shame (shame *in* the body) and anxiety implicates the client's physiological stress response. In the case of persistent sexual problems, the client may experience a biopsychosocial feedback loop, in which cognitions about sexual behaviour are linked to feelings of shame and anxiety, and trigger an inhibiting physical stress response (de Jong, 2009; Leiblum & Wiegel, 2002). In this cycle, the body's stress reaction may function as a mediating factor between emotional and cognitive processes—specifically anxiety and shame—and the inhibition of sexual response. This biopsychosocial process may operate as a conditioned response, largely outside of the client's awareness. Additionally, the data support the interpretation that psychosexual symptoms may often be influenced by a client's behavioural pattern of avoidance of, or reluctance to engage with, the embodied experience of a sexual relationship, which may carry an implication of performance-demand-based anxiety, or anxiety about sexual failure, as discussed in chapter 7.

These patterns of stress-induced avoidance implicate the increased prevalence of technologically-mediated communication, as a factor in sexual and relationship difficulties, an apparent sub-theme in the qualitative data. In this respect,

technologically mediated communication, in Britton's terms, is seen as "really related to not being in a body. And culturally, systemically, people are being forced into a techno-mind world. Too much virtual, not enough physical embodiment" (research interview, 23/02/2012, transcript p. 8, lines 24-26). This "techno-mind world" may reflect, or contribute to, another sub-theme identified in the qualitative data: the client's avoidance of intimacy, and of immediate, embodied communication and connection. By consequence, technologically mediated communication may be correlated with relational avoidance, rooted in the client's anxiety and "fear, avoiding feeling vulnerable. Avoiding being really and truly known" (Britton, research interview, 07/03/2012, transcript p. 6, lines 26-27). These findings indicate that further research is warranted to establish the possible links between technologically-mediated communication, attachment styles (prospectively avoidant attachment styles), and the development of sexual relationship schemas that inhibit sexual functioning, as these behaviour patterns are observed by several clinicians interviewed here.

Additionally, Britton and other research participants emphasize the influence of shame *about* the body, which is viewed as "an endemic aspect of most people's sexual experience. I've never met anybody who doesn't have some shame in their sense of self, their body image, their functioning" (Britton, research interview, 23/02/2012, transcript p. 8, lines 18-20). As is illustrated throughout this chapter, interview data, and the wider psychological, and socio-psychological research, provide evidence that shame about the body is powerfully cultivated by a variety of socialization experiences, and often has a negative impact on sexual functioning and sexual satisfaction (Daniel & Bridges, 2010; Sanchez & Kiefer, 2007; Wiederman, 2002). Men's feelings of anxiety and shame about the size and shape of their bodies, and the size and shape of their genitals, are noted in the research literature across fields of study, with body-related shame being implicated as an inhibiting factor in the development and maintenance of a satisfying sexual relationship (Davis, Paterson, & Binik, 2012; Lee, 1996; McKee, 2013; Veale et al., 2014; Wylie & Eardley, 2007).

8.5. Long-term Monogamy as 'Anti-Natural'

Data from this study support recent research from the attachment field, suggesting that many sex therapy clients present with a psychosocial conflict between sexual eroticism and companionate intimacy. As discussed in chapter 5,

(see tables 5.6 and 5.7, appendices K and L), the importance of relational intimacy for sexual functioning is a prominent theme in the qualitative data, with a number of respondents indicating that reconnecting the couple (where the client is in a couple relationship), or building the capacity for intimacy is a common, overarching clinical goal. Additionally, a subset of research participants emphasize that there is a difference—and often a tension—observed between intimacy and eroticism in couple relationships. McCarthy, for instance, holds that a primary "challenge for couples is: how you integrate intimacy and eroticism into the same relationship" (research interview, 17/01/2013, transcript p. 5, lines 22-23). Within adult attachment research, a similar distinction is made between "passionate love" and "companionate love". Within the attachment model, "passionate love" is defined as "a state of intense longing for union with another" (Hatfield & Walster, 1978; Kim & Hatfield, 2004, p. 174), whereas, "companionate love" is seen as "less intense…a warm feeling of affection and tenderness that people feel for those with whom their lives are deeply connected" (Hatfield & Rapson, 1996; Kim & Hatfield, 2004, p. 175). It has been suggested that passionate love characterizes the early stages of a sexual/romantic relationship, while companionate love characterizes later stages (see also chapter 9, section 9.2.3)(Hendrick & Hendrick, 1994). Further, Eagle has suggested that there is a fundamental biological antagonism between the attachment and sexual systems, with attachment overriding sexual desire and arousal in enduring couple relationships (Eagle, 2011). Within this model, sexual desire in the early stages of a relationship serves to maintain proximity between two sexual partners long enough for an attachment relationship to be established. Herein, eroticism is seen as operating largely in the service of intimate, long-term pair bonding.

In this respect, a number (5.9%) of interviewees express the concern that sexual desire and long-term monogamy are inherently opposed or incompatible (see also table 7.1 and 7.2, appendices Q and R). Consequently, one interviewee holds, a significant issue in long-term monogamous relationships, "is sexual boredom or ennui. And that's one of the huge components: we're not wired biologically to stick it out with a partner" (Britton, research interview 23/02/2012, transcript p. 9, lines 2-3). Here, the data suggests that waning sexual desire, or the loss of sexual eroticism in a long-term relationship, may be a routine problem faced by sex therapy clients. Openshaw describes the psychosocial aspect of this phenomenon as, "ordinariness—how relationships get dull over time, and how that ordinariness has to be managed, and the habituation of sexual contact, when it's kind of got too routine and there's no

energy connected to it for people" (research interview, 26/02/2013, transcript p. 4, line 46, p. 5, lines 1-2). Recent published research appears to support this theory, indicating that interlinked biological, psychological, and social aspects of this "boredom" or "ordinariness"—rooted in the attachment system—contribute to the development of sexual problems in enduring couple relationships (Diamond, Blatt, & Lichtenberg, 2011; Eagle, 2011; White & Schwartz, 2007).

The following excerpt from a research interview helps illustrate the interrelated biopsychosocial aspects of diminished sexual desire and sexual behaviour in long-term relationships. The interviewee states:

> I just look at evolution, and I explain to [the client] why evolution makes it so that…we're almost primed not to want someone after a few years anyways. And then you have to resort to little tricks of the trade. You have to wear sexy lingerie, you have to do this or that. But above all, you know, you have to be happy with the person. And if there's unspoken resentments or anger, well, that's the first thing that goes. People are not going to want to have sex with each other. And so then we need to go there. With men, a lot of times, it's performance anxiety. Because the wife—what happens is the wife, or the partner, the female all of a sudden is not responding sexually as she has in the past, which, I tell them is normal. I normalize that from the very get go. I tell people: we are not monogamous. The fact that we stay together is an artificial construct, and it's part of our cultural sexual scripting. But now we do. And now we have to fool Mother Nature (Milrod, research interview 11/10/2012, transcript p. 8, lines 27-40).

As this quote illustrates, in Milrod's view sexual functioning within a long-term couple relationship is highly vulnerable to the influence of problems (i.e. unspoken resentments or anger) in the relationship more broadly. Additionally, behavioural interventions ("tricks of the trade") are seen as essential in trying to "fool Mother Nature," and maintain a satisfying sexual relationship across time.

Another interview excerpt advances this conceptualization of how the sex therapist may work with the couple to help them enhance or optimize sexuality within a long-term relationship. It is important to note that the interviewee, Openshaw, places a high level of emphasis on working with both members of the couple, in cases of sexual "ordinariness" or "dullness," because,

> if I've only got one half of the couple, it would be very difficult to deal with that. If I've got the pair, then it's much easier, because the importance, first

> of all, is to kind of name it—that it's got dull. And to actually think about what both might need to request of the other. So, what I find most people do when it's got dull is they've forgotten some of the things that they used to explore when they were more engaged in sexual contact. And because they know what works, people go straight to the spots that work, as opposed to exploring bits that may not, that may have worked before and they've been ignored. So I think people get involved in probably too much physical contact at the end of the day, when they're tired, it's kind of like "ok, well I'm going to do what I'm going to do because I know it works". And that's the lack of effort that people put into their sexual relationships…it's kind of ticking it off like a list of jobs that you've got to do at the end of the day. And so, what they haven't considered is: how do they build up desire? How then in the contact do they think about what the other person wants and needs? What they want and need, and whether they make requests around it? And then the kind of dullness of doing the same thing. And quite often, you see, I'm working with people who have been in relationships for quite some time with each other, and so it's got dull (Openshaw, 2013, p. 329).

Openshaw conceives of "dullness" as effectively synonymous with "ordinariness" in the sexual life of the couple. This concept is comparable to the sexual unresponsiveness in long-term partnerships described by Milrod, and the "boredom" identified by Britton above. According to the interview data, with respect to clinical intervention (a topic addressed at greater length in chapter 9), the emergence of sexual boredom warrants a number of therapeutic objectives, including: identification and acknowledgement of the problem (i.e. naming the problem as sexual "boredom" or "dullness"), and implementation of behavioural strategies to reduce the "ordinariness" or "dullness" the clients experience. However, another more fundamental shift is seen as necessary: a shifting of the client's mentality about what sex is, and what role it fills in the couple relationship.

Data from this study, wider published research, and the plethora of books on 'rekindling sexual desire' in long term couple relationships suggest that sex therapists widely view the reduction of sexual desire and eroticism in long-term monogamous relationships as common. For many sex therapists, an overarching conceptualization of sexual problems in long-term relationships appears to be grounded in the theory that sexual desire—seen as an inherent driving force for eroticism—decreases over time. Desire, as Levine defines it, "is the sum of the

forces that leans us toward and away from sexual behavior" (2003, p. 279). As such, alongside dysfunctional or unsatisfying behavioural patterns—for instance, fixating on performance and outcome, or adhering to a narrow range of predictable sexual behaviours—a reduction in sexual desire and sexual motivation is seen as a common, and often challenging, aspect of long-term sexual partnership.

Finally, a segment from a research interview with McCarthy helps instantiate the widespread conceptualization of passionate versus companionate/intimate relationship, and the fundamental shift in perspective—towards a model that integrates passion and companionship, eroticism and intimacy—that is seen as a means for working therapeutically with the couple relationship. McCarthy states,

> I think for the majority of couples, and I really mean the majority of couples, they have a period somewhere between six months to a couple of years that is kind of a: romantic love, passionate sex, idealization period. It's a wonderful period, and it doesn't last, no matter how loving or sexually functional they are. The challenge for them is to develop a way of approaching sex and sexual desire that really is going to work for them in an ongoing relationship, and for so many couples they never do that. And what actually happens for them, I think, and I think this is the key element in couples where they have lost desire for each other, is they have a way of being sexual that is not inviting to either one, and it's usually not inviting to the woman. So they get into a routine where sex is intercourse-focused, not pleasure-focused. Now, in terms of rebuilding desire, I think for the majority of people that is very doable…. I think for the great majority of couples rekindling or rebuilding desire is not only possible, but it's preferable, and that the key to doing that is finding a new couple sexuality that integrates intimacy, pleasure and eroticism (research interview, 17/01/2013, transcript p. 7, lines 22-39).

As stated above, a well-established body of published research indicates that performance-oriented perspective on sexuality, which is focused on penetration and orgasm, may often be an impediment to sexual satisfaction (Althof, 2006a; Bruce & Barlow, 1990; McCabe, 2005; McCarthy & Thestrup, 2009b). Qualitative data in this study also suggest that the performance-oriented sexual behaviour script often increases the likelihood of sexual difficulties, and that, as stated previously, a performance-orientation may often be better replaced by a pleasure-focused model of sexual behaviour (see tables 7.1 and 7.2, appendices Q and R)(Metz & McCarthy, 2007). The data from this study appear to support McCarthy's assertion that, rather

than focusing on desire and intercourse, it may often be therapeutically beneficial for the client/couple to focus on intimacy and pleasure.

Evidence suggests that, for many sex therapists, the objective of helping the couple to integrate intimacy and eroticism in their sexual relationship may best be supported by intervention at the level of the couple relationship, involving both members of the couple dyad (as discussed in chapter 5 above)(Berry & Berry, 2014; Hertlein, Weeks, & Gambescia, 2009; Meana & Jones, 2011). To a large degree, this orientation, and the treatment strategies specified in this section, are situated at the social level, and are intended to address aetiological factors that are largely psychosocial and relational. In addition, however, the data indicate that it may often be therapeutically valuable to examine the individual psychological processes that may underlie sexual problems—for instance to work with maladaptive thoughts and beliefs that are held by the client individually.

8.6. The Role of Maladaptive Mentalization: Using Mentalization-based Theory to Interpret Aetiological Factors

Published evidence suggests that the ways in which a client understands, or mentalizes, the sexual problem—in terms of both the individual and relational elements of the problem—is a key factor in the sexual dysfunction (Aanstoos, 2012; Berry & Berry, 2013b; Jones et al., 2011). For many sex therapists, it appears, the problem itself is inseparable from the problem *as it is understood* by the client, a fact underscored by the high emphasis placed on the client's subjective understanding of the sexual problem (see also chapter 7). Consequently, assessment of aetiology must take account of what sexuality and sexual functioning signify for the client, at the level of personal meaning. As one interviewee states, "I think the basis of most psychological problems are: the way one frames the situation to oneself" (Alman, research interview, 09/01/2013, transcript p. 1, lines 27-28). In this respect, mentalization-based interpretation of the aetiology of the dysfunction, which examines the client's explicit and implicit capacities for understanding the sexual problem in a personal and relational context may be especially useful.

Luyten, Fonagy and colleagues have proposed a multidimensional model of mentalization in which the client's capacity to mentalize thoughts, feelings and motivations is defined by four polarities:

1. Automatic (implicit)—Controlled (explicit)
2. Internally focused—Externally focused

3. Self-oriented—Other-oriented
4. Cognitive Process—Affective Process (Fonagy, Bateman, & Luyten, 2012b)

The polarity between automatic/implicit mentalizing and controlled/explicit mentalization, Fonagy and colleagues state, is "most fundamental" (2012a, p. 20). Controlled (explicit) mentalization involves slower, largely verbal, reflective, attentional, intentional, and effortful serial cognitive processing (Allen, Fonagy, & Bateman, 2008), whereas automatic (implicit) mentalization involves faster, reflexive parallel cognitive processing, and negligible attention, intention, awareness, or effort (Satpute & Lieberman, 2006). More simply put, implicit mentalization might be conceptualized as an involuntary and intuitive process, whereas explicit mentalization involves a process of active, intentional reflection. Healthy mentalizing includes the ability to switch, readily and voluntarily, from implicit to explicit mentalizing (from intuition to active reflection). Particularly significant for the treatment of sexual problems is the empirical observation that stress and arousal activate the automatic mentalization system and inhibit controlled/explicit mentalizing (Lieberman, 2007). These findings suggest that—since reducing stress and arousal is essential for controlled mentalizing, and for sexual functioning—stress reduction techniques may be a vital element of successful therapy.

The polarity between internally focused mentalization and externally focused mentalization captures the distinction between thought and feelings (internal), and behaviours and physical qualities (external) (Fonagy et al., 2012a, p. 23; Satpute & Lieberman, 2006). Mentalization about the interactions between internal and external features of self and others may be particularly important in the treatment of sexual dysfunction, by virtue of the high level of emphasis sex therapists place on the relational dimensions of sexuality and sexual functioning. Where internally focused mentalization describes "mental processes that focus on one's own or another's mental interior (e.g. thoughts, feelings, experiences" externally focused mentalization describes "mental processes that rely on physical and visible features and one's own or another's actions" (Fonagy et al., 2012b, p. 22). The individual's capacity to reflect on the reciprocal interactions between sexual behaviours/actions and thoughts/feelings is especially crucial in considering the way in which mentalization may be implicated in sexual function and dysfunction.

To understand the role that deficits or maladaptations in the individual's capacity to mentalize with regard to self and others, the clinician may evaluate: (1)

the client's mentalizing about both the self and others (especially a sexual or relationship partner), (2) any significant imbalances between mentalizing about the self and mentalizing about others, and (3) any specific types of imbalance or deficit in mentalizing about the self and others (particularly with regards to sexuality, intimacy, or attachment). According to Fonagy et al.:

> both clinical practice and neuroimaging research suggest that there are two different ways of knowing oneself and others. The embodied, visceral, unmediated system (reflecting automatic processing) . . . [and] the more abstract system [which] involves symbolic reasoning about one's inner states of mind (reflecting more controlled processing)(2012b, p. 26).

In addition, it is important to note that a well-developed capacity to mentalize involves a conceptual integration of cognition and affect—the ability to conceptualize and understand the interplay of thoughts and feelings both in terms of self and others, and within a sexual and relationship context (Jurist, 2005).

A mentalization-based framework for interpreting sexual problems may help illuminate the systems of meaning and understanding the client associates with sex and sexuality—which, for many sex therapists, appears to be preeminent in understanding the multi-factorial causal pathway of sexual problems. As one interviewee, Alman, states,

> a lot of [clinical work] has to do with all kinds of nonsense that people tell themselves. Whether they've learned that nonsense at their parents knee, or their pastor's knee, or on the cover of Cosmopolitan magazine, they still have some really bizarre ideas about men or women, or how sex is supposed to be conducted…It's nonsense. I'm going to tell you it's nonsense, and I'm going to show you a better way to conduct your life than being ruled by something that's not true, or doesn't work for you.
>
> Berry: Yeah, absolutely. So it's sort of, if I understand you correctly, distorted and maladaptive thought process and beliefs that come into play?
>
> Alman: That's 99% of it (Alman, research interview, 09/01/2013, transcript p. 12, lines 18-30).

Alman de-emphasizes the origins of "nonsense" thought processes, preferring to focus on shifting the thought processes that trouble sexual functioning using cognitive behavioural techniques (Alman self-identifies as a CBT practitioner). By contrast, many other interviewees indicate that they seek to examine and uncover the causal factors that may underlie maladaptive thought processes and dysfunctions in

the client's mentalizing capacity (a point discussed further in chapter 9). This process often involves an examination of the ways in which maladaptative patterns in thought/mentalizing are grounded in, or linked to, to earlier experiences. One interviewee, for instance, describes the earlier life variables that may be of importance in understanding the aetiology of sexual concerns, emphasizing the importance of examining the client's affective and cognitive process; she states,

> we do a basic, well, I suppose there's nothing basic about it—back to roots psychotherapy program, in terms of them looking at their childhood and gaining insights from messages that they've received, the internet, parent role models that they had, in terms of early memories, potential traumas around that time, or those years, how they first learnt about sex. We look at how they process their emotions. How they process their thoughts (de Vries, research interview, 05/02/2013, transcript p. 2, lines 40-45).

Qualitative data suggest that many sex therapists emphasize the importance of understanding the ways in which clients process thoughts and feeling—and each client's capacity to mentalize according to the framework defined above—in order to comprehend the multifactorial aetiology of the sexual problem.

With respect to clients' abilities to process thoughts and feelings, it may be important to consider the role of reflective functioning (discussed further in chapter 9)—a primary measure of the individual's capacity to mentalize (Fonagy et al., 2012b; Fonagy & Target, 1997; Fonagy, Target, Steele, & Steele, 1998b). The individual's reflective functioning may be measured formally, or informally (Bouchard et al., 2008; Fonagy, Target, Steele, & Steele, 1998a), and while none of the psychotherapists surveyed in this study indicated making use of formal measures of reflective functioning, interview data suggests that attention to the client's mentalizing and reflective functioning capacity may be an important implicit element in the therapist's assessment of clients' sexual difficulties. By definition, mentalizing effectively requires a reflective understanding of the dynamic nature of thoughts and feelings; to mentalize is to understand thoughts and feelings, in light of their intentionality. In light of mentalization-based theory's clinical content, this model's prospective utility—either implicitly or explicitly—in the interpretation of sexual and relational problems is unsurprising. Mentalizing is understood as "attending to mental states in self and others," and is recommended as a framework for application in extant, and diverse, psychotherapy models (Allen et al., 2008, p. 3).

The importance of mentalizing capacity—especially reflective functioning—in the client was an apparent theme in the qualitative data (emphasized by 26.5% of interviewees). Additionally, a number of interviewees (11.8%) stated the view that the psychotherapy relationship itself (i.e. the relationship between client and therapist) serves to foster mentalization and reflective functioning in the client, and/or mirror outside relationships. This emphasis on the client-therapist relationship—identified by Ablon and Jones (Ablon & Jones, 1998) as a prototypical technique in psychodynamic psychotherapy—suggests the potential for further application of mentalization-based practice in the treatment of sexual problems.

Overall, while the data support the hypothesis that psychosexual therapists use mentalization-based techniques and associated concepts in clinical practice, especially to understand the aetiological course of the client's function, this application appears to be largely implicit—a finding that accords with prior research, which suggests that a variety of clinical modalities serve to foster mentalization and can be assessed according to a mentalization-based theoretical framework (Allen, 2008a; Björgvinsson & Hart, 2006; Fonagy, Bateman, & Bateman, 2011). Finally, it must be noted that, to date, research on the use of mentalization-based therapy techniques as *interventions* in the treatment of sexual problems is negligible (the potential for explicit application of mentalization-based theory/technique—as a means for integrating psychodynamically-informed methods—in the treatment of male sexual dysfunction, is further discussed in chapter 9).

8.7. Aetiology: The Unconscious Meaning of the Symptom

As with sexuality more broadly, emphasis on the meaning, or meanings, of the symptom itself, within the psychology of the individual client, was a salient theme in the data. Consonant with published psychology and psychotherapy research, which suggests that psychological symptoms may serve a current or anachronistic function or purpose within the individual's psychology and relationships, data in this study suggest that sexual symptoms often serve a psychological purpose, and consist in a structure of psychological and psychosocial meanings, for the client (Fish, Fish, & Sprenkle, 1984; Kazdin, 1982).[35] It is also important to note that a theory that the symptom serves a psychological purpose is

[35] It is noteworthy that conceptualizations of the functional purpose of psychological symptoms have come into prominence in the fields of systemic and family therapy (Atwood & Weinstein, 1989; Gurman & Kniskern, 2014; Miermont, Jenkins, & Turner, 1995). The connection between these fields and psychosexual therapy, with respect to the functional aspect of the client symptom within the relational system, is an important area for current and ongoing work.

prominent within psychodynamic and psychoanalytic theory, with respect to sexuality, to the operation of psychological defence mechanisms (discussed further in chapter 9), and to the process of psychotherapeutic work (Morel, 2011; Stewart, 1963).

Qualitative data from this study indicate that the underlying unconscious function or meaning of the symptom is an important consideration for many clinicians, with 41.2% of interviewees indicating that they work to identity an unconscious function/meaning of the client's symptom in their clinical practice. As discussed above, the data also suggest that clinicians often work to uncover the wider meanings that the client associates with sex and sexuality, with insight into these meanings being an underlying clinical objective. Consequently, the data appear to support the view that psychodynamic and psychodynamically-informed techniques that focus on unconscious processes may be of value as the therapist works to help the client understand how underlying meaning structures contribute, often unconsciously, to a sexual problem (a consideration addressed at greater length in chapter 9). The objective here, as Dunn illustrates with a compelling and pithy turn of phrase, is to understand "the function of the dysfunction" (research interview, 29/01/2013, transcript p. 5, line 8).

An example from the study author's own clinical work may help illustrate a psychodynamic interpretation of the "function of the sexual dysfunction" within the psychology and relationship of a client. In order to protect the anonymity and confidentiality of my clients, the data presented here is reported anonymously, and represents a synthesis of case material from a number of different clients. Additionally, a number of key details (i.e. age and demographic details) have been altered.

CASE STUDY:

> A male client in his late twenties presented with relationship difficulties, and recent problems with sexual functioning, including reduced desire and difficulty maintaining an erection. He reported being generally happy/healthy in all aspects of his life, but assessment indicated that interpersonal conflict, marked by increasingly frequent arguing, had recently emerged in his relationship with his female common-law partner of four years. The central theme of the arguments, identified by the client, was his partner's declared desire to have a baby, and his own reluctance/disinclination to become a father. The client's sexual history

> revealed that the emergence of sexual symptoms in the client—including reduced desire and difficulty gaining and maintaining an erection—was subsequent to the onset of this relationship issue. The client indicated no prior history of sexual dysfunction, and stated that he found the relationship otherwise satisfying, and "harmonious".

Interview data suggest that conflict over whether to have a child may be a commonplace issue for couples presenting for sexual therapy (most of the qualitative data on this theme speaks directly to heterosexual couples, and the role that this factor may play for LGBTQ couples is an important area for additional research)(Dunn, research interview, 29/01/2013; Seymour, research interview, 04/07/2013).

In the clinical work with the aforementioned client, a salient meaning underlying the symptomatic presentation was the client's aversion to the prospect of becoming a father (an affective response that increasingly shifted towards ambivalence about having a child with his partner, and previously unidentified ambivalence about other aspects of the relationship during our work together). In the initial case formulation, these averse and ambivalent feelings were identified as a likely contributing element in the client's sexual problems. For this client, it appeared, sex had come to 'mean' having a child, and entrapment within a relationship that he felt unsure about, and to a certain measure his sexual problems appeared to reflect an embodied resistance to this possibility. One interviewee underscores the importance of this kind of contextual formulation, stressing that, in understanding the causal pathway for sexual dysfunctions, it is imperative to avoid getting "caught up in" questions about sexual functioning, such as: "'how does your dick work?' or 'How does your Vagina Lubricate?'—as opposed to: 'what is the meaning that's driving the behaviour?'" (Winn, research interview, 16/01/2013, transcript p. 5, lines 4-5).

As Barker stresses, it is necessary to acknowledge "the importance of symptoms' meanings," and amongst these meanings we may include "intrapsychic, interpersonal, systemic, and socio-cultural values" (Barker, 2011a, p. 35). It is also important to note that, rather than identifying a single, unidimensional meaning, each client is apt to hold multiple meanings about sex, sexual functioning and sexual problems, and the interplay of psychosocial factors that surround these issues. Extrapolating from the research interviews conducted here, a number of conclusions may be drawn regarding the role of unconscious meanings in the development of

sexuality and sexual dysfunctions. First, it is clear that, while certain meanings associated with sex, or sexual dysfunction, may be particularly prominent, meanings are multi-dimensional, and the client may hold mutual—and even contradictory—meanings surrounding sex, at different levels. The meanings of sex and sexual symptoms exist within a relational context, and are apt to vary across time. Additionally, data suggest that: 1) meanings can consist at both conscious and unconscious levels, and 2) gaining deeper insight into these meanings is seen as a mechanism for therapeutic change. Thus, helping clients to be aware of, and gain an insightful understanding of, these meaning systems, is widely seen as an important clinical priority. Finally, by virtue of the unconscious dimensions of sexual functioning, and the meanings attached to it, psychodynamic methods may be of value in helping the client to gain an insightful understanding of the aetiological processes that contribute to sexual dysfunction, and psychosexual and relationship problems, a consideration taken up in the following chapter.

8.8. Evaluating Aetiology: Summary of Findings

Chapter 8 has described the data on clinicians' perceptions of the aetiology of clients' sexual problems. As indicated, a multi-factorial view of aetiology appears to be prevalent, and interviewees emphasize the importance of considering multiple interrelating causal factors. High emphasis is also placed on the client's early life and developmental experiences as potential aetiological factors. This focus on the client's early life appears to encompass assessment practices (discussed in chapter 6), practices in goal-setting and case formulation (discussed in chapter 7), aetiological theories (discussed in this chapter), and principles of intervention. It is also is a basis for the inclusion of psychodynamically-informed principles in the treatment programme (discussed in chapter 9).

This chapter also presented data on a number of key cognitive and affective processes that are seen as common in the aetiology of clients' sexual problems. The influence of religion, anxiety, guilt and shame were particularly prominent in the data. The role of embodiment in negative cognition and affect—especially anxiety, guilt and shame—also appears to be an important consideration for sex therapists. Finally, in considering aetiology it is worthwhile to re-emphasize one of the most prominent findings of this research: that clinicians place a high level of emphasis on unrecognized relational and interpersonal processes in sex therapy, and in interpreting the aetiology of individual clients' sexual problems. This high emphasis

on psychosocial processes informs the description in section 8.6. of mentalization-based theory as a useful new framework for conceptualizing sexual problems in clinical practice (Berry & Berry, 2013b). Data indicate that clients may often bring a limited awareness of the relational dimensions of sexual problems and, as discussed in section 8.7, the unconscious meaning of a symptom, or the unconscious purpose it may serve. The importance of unconscious factors, and other psychodynamic concepts, is further evaluated in the following chapter.

CHAPTER 9. THE PLACE OF PSYCHODYNAMIC PRACTICE IN SEX THERAPY

9.1. Introduction: The Contemporary Place of Psychodynamic Practice in Sex Therapy

Chapter 9 describes the data on the current place of psychodynamic practice in sex therapy. The chapter seeks to answer the primary question of this research project, and indicate the extent to which psychosexual specialists currently employ psychodynamic techniques in treating male sexual dysfunction. This chapter is intended to satisfy the primary aim of this research project, by accomplishing a number of tasks. The chapter aims to:

- identify the role of psychodynamic methods in sex therapy, as reported by sex therapists and psychotherapists surveyed,
- evaluate the use of psychodynamic techniques in relation to cognitive behavioural techniques,
- consider the distinction between the implicit and explicit use of psychodynamic techniques in the sex therapy field, and
- further explore the role of key psychodynamic and psychodynamically-informed concepts in the data from this study (many of which have been identified in previous chapters). These key concepts include the relational perspective, the use of attachment theory, and the use of mentalization-based therapy.

In short, this chapter aims to illustrate where psychodynamic methods may fit in sexual practice *now*, in the contemporary treatment context.

An acknowledgement of psychodynamic factors—loosely gathered under the framework of "developmental factors"—is evident in the early sex therapy literature

(Kaplan, 1974b; Leiblum & Pervin, 1980; Masters & Johnson, 1970). Masters, Johnson and Kolodny provide a general list of psychosocial antecedents for the sexual disorders, which illustrate this attention to developmental factors; amongst these, they include,

> troubled parent-child relationships, negative family attitudes toward sex, traumatic childhood or adolescent sexual experiences, and gender identity conflicts [which] may all predispose one toward developing later sexual dysfunctions, either singly or in combination (1982, p. 379).

However, the predominantly cognitive behavioural treatment system developed by Masters and Johnson, and the ostensively widespread conception that sex therapy is a principally CBT-based treatment area, may inhibit the perception that psychodynamic practices are an integral or essential element of integrative sex therapy. Additionally, it appears that the contestation of psychoanalytic and psychodynamic methods in the wider field of psychology has had a significant impact on the apparent role of these methods in the sex therapy specialization (Berry, 2013a, 2013b). Qualitative data from this survey suggest that many sex therapists and allied researchers do not see the sex therapy specialization as including psychodynamic techniques to a significant degree, as few discuss the role or application of psychodynamic methods specifically. This research project, however, is predicated on the hypothesis that the actual use of psychodynamic techniques by sex therapists and generalist psychotherapists working in the treatment of male sexual dysfunction may often be overlooked or unidentified, even by practitioners who use them.

Chapter 9 describes the quantitative evidence from this study on the use of prototypical psychodynamic techniques versus prototypical cognitive behavioural therapy techniques, amongst psychotherapists and sex therapists surveyed. Specifically, this chapter assesses the degree to which survey respondents report using:

1) prototypical psychodynamic and cognitive behavioural therapy techniques, and
2) distinctive psychodynamic and cognitive behavioural therapy techniques

in the treatment of male sexual problems. The chapter proceeds to identify a number of psychodynamic techniques that, according to the quantitative and qualitative data in this study, appear to be used most commonly in the treatment of male sexual

dysfunction, and describe key clinical frameworks and techniques drawn from psychodynamic theory, which are supported by the data in this study. Drawing on qualitative data from research interviews, the chapter also outlines some of the clinical strategies that may be used for implementing these key psychodynamic techniques within an integrative treatment schema.

9.1.1. Contemporary use of Prototypical Psychodynamic and Cognitive Behavioural Therapy Techniques in the Sex Therapy Field

In section 1 of this dissertation, the research on psychotherapeutic approaches to the treatment of male sexual problems was reviewed. It was argued that a generally cognitive behavioural orientation to psychosexual therapy is widely assumed, and that attention to psychodynamic methods is limited in current research (Berry, 2013a, 2013b; Hartmann, 2009; Waldinger, 2006). It was also found that, while there is evidence that psychodynamic techniques may be an important component of current psychosexual therapy practice, substantive research on the use of psychodynamic theory and technique in the contemporary sex therapy field is extremely lacking. Consequently, the research findings presented below, and throughout this dissertation, may provide new information on an under-researched area. This section reports the main findings on the degree to which questionnaire respondents report using psychodynamic and cognitive behavioural therapy techniques, respectively, in clinical practice.

A more comprehensive overview of survey development and methodology is provided in chapter 4 above; however, a number of methodological aspects in the development of the prototypical and distinctive categories of psychodynamic and cognitive behavioural therapy practice are worth emphasizing here. First, as stated in chapter 4, a set of techniques considered prototypical of psychodynamic therapy, and a set of techniques considered prototypical of cognitive behavioural therapy (CBT), were identified and validated through pilot testing. This section first illustrates (in figure 9.1 and 9.2) the degree to which sex therapy and psychotherapy generalist respondents report using these prototypical psychodynamic and cognitive behavioural techniques, for: all respondents, for sex therapy specialists, and for psychotherapy generalists.

Here, the results of two aggregated/summated, multi-item scales, which measure the degree to which respondents report using 1) prototypical psychodynamic methods and 2) prototypical cognitive behavioural therapy methods in the treatment

of male sexual dysfunction, are presented. 20 questions on the use of prototypical psychodynamic methods and 20 questions on the use of prototypical cognitive behavioural therapy methods were asked. Each question measures the degree to which respondents use a specific psychodynamic or CBT technique, using a five point Likert scale, ranging from 1="not at all," to 5="to the maximum possible degree". The 20-question subset for each modality was combined into a summative score, measuring the overall degree to which respondents report using the prototypical psychodynamic methods, and prototypical CBT methods, respectively, with the last case of male sexual dysfunction they treated.

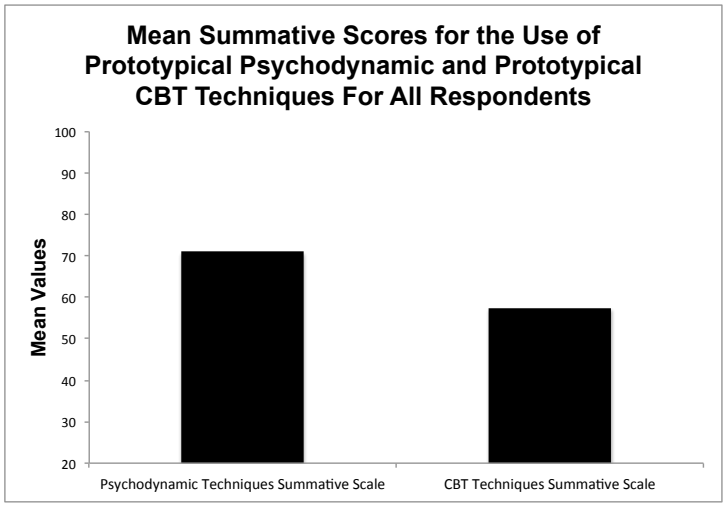
While no single technique is reflective of a tendency towards psychodynamic practice or CBT, it is assumed that, in aggregate, respondents' scores on the prototypical psychodynamic and CBT scales may reflect a tendency towards these methodologies.

Additionally, while the techniques evaluated have been validated as reflecting these respective psychotherapy frameworks by prior research, it is important to note that a number of these techniques may also be viewed as common factors within contemporary psychotherapeutic practice (Asay & Lambert, 1999). Consequently, while the forty distinct techniques examined here are considered prototypical of, and fundamental to the practice of, psychodynamic psychotherapy and CBT respectively, a number of the techniques assessed are neither unique nor exclusive to either of these modalities. Therefore, in addition to presenting aggregate scales representing respondents' adherence to prototypical psychodynamic and CBT techniques, a sub-set of 8 techniques for each modality, which may be considered *distinctive*, characteristic techniques of the modality, have been identified (listed in appendix W). Research participants' adherence to these technique subsets—designated as "distinctive psychodynamic techniques" and "distinctive cognitive behavioural therapy techniques"—are described in figure 9.3, and tables 9.1 and 9.2 below.

9.1.2. Questionnaire Results: Contemporary Use of Prototypical Psychodynamic and CBT Techniques

Figure 9.1 shows the total mean scores for all respondents, for use of prototypical psychodynamic and prototypical CBT techniques. Respondents' scores for all psychodynamic and CBT questions were aggregated into two summative scales, with a possible value range of 20-100.

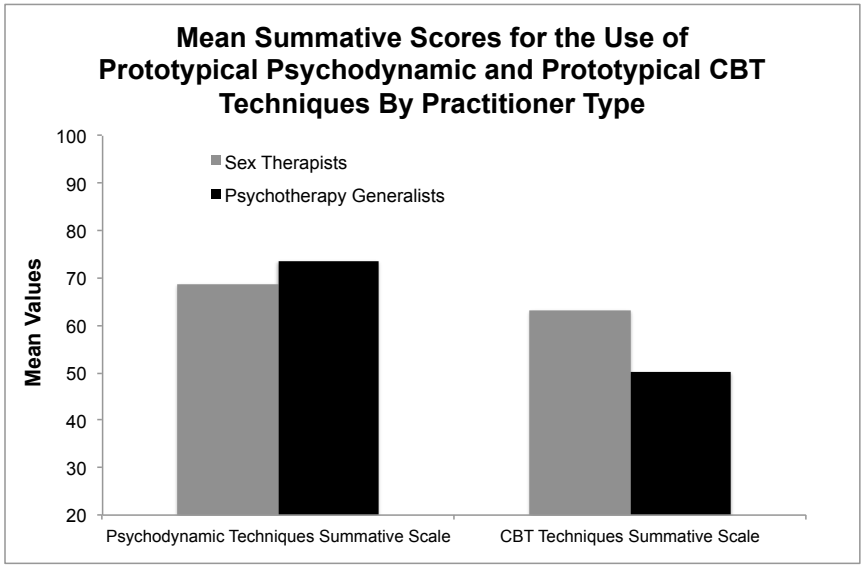
Figure 9.1: Mean Summative Scores for the Use of Prototypical Psychodynamic and Prototypical CBT Techniques For All Respondents



An independent samples t-test was performed to determine if there is a statistically significant difference in the mean scores of all respondents on the summative scales measuring the use of prototypical psychodynamic techniques (M = 70.93) and CBT (M = 57.46) techniques. A statistically significant difference was found, showing a higher rate of adherence to the psychodynamic techniques, relative to the CBT techniques $t(316) = 10.089$, $p < 0.001$. Consequently, for all respondents, a higher level of adherence to prototypical psychodynamic techniques, in the treatment of the most recent male client, was reported, relative to adherence to prototypical CBT techniques.

Figure 9.2 compares the mean scores for sex therapy specialists and psychotherapy generalists, on the summative scales for use of prototypical psychodynamic and prototypical CBT techniques. Once again, respondents' scores for all psychodynamic and CBT questions were aggregated into two summative scales, with a possible value range of 20-100.

Figure 9.2: Mean Summative Scores for the Use of Prototypical Psychodynamic and Prototypical CBT Techniques By Practitioner Type



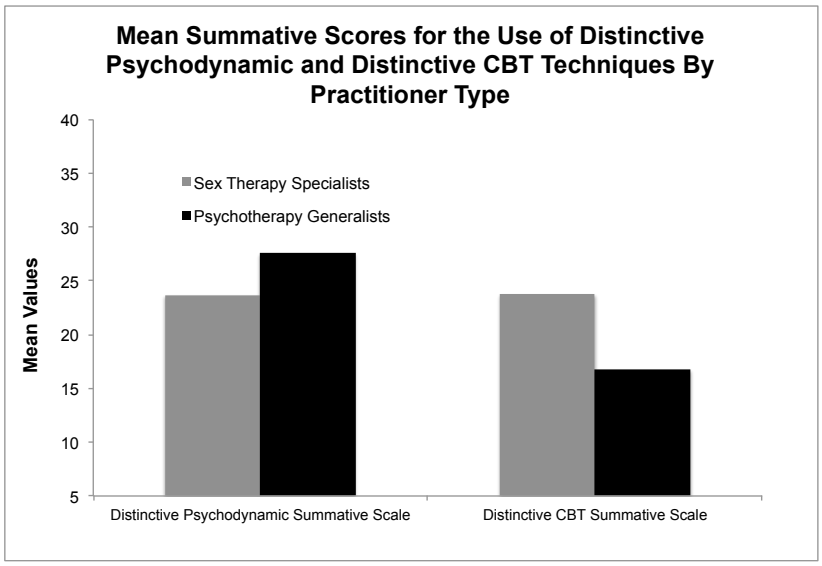
A two-way repeated measures ANOVA was performed on the factors of practitioner type (Sex Therapists versus Psychotherapy Generalists; between-subjects) and summative scales (Psychodynamic Techniques versus CBT Techniques; within-subjects). For summative scales, a main effect was found, showing that respondents' self-reported adherence to the psychodynamic techniques ($M = 70.93$, $SD = 10.84$) was higher than the adherence to the CBT techniques ($M = 57.46$, $SD = 12.88$), $F(1, 157) = 208.208$, $p < 0.001$. An interaction of summative scales and practitioner type was also found, showing that the discrepancy between adherence to psychodynamic and CBT techniques was greater within the psychotherapy generalist group ($M = 73.75$, $SD = 9.49$, $M = 50.30$, $SD = 10.55$ respectively), than the sex therapists group's adherence to psychodynamic ($M = 68.74$, $SD = 11.41$) and CBT techniques ($M = 63.24$, $SD = 11.66$), $F(1, 157) = 79.711$, $p < 0.001$. This finding indicates that psychotherapy generalists were more discriminant in their adherence to different techniques. A main effect of practitioner type was found, where sex therapists ($M = 65.99$, $SE = 0.95$) showed higher levels of adherence to both technique sets than psychotherapy generalists ($M = 61.97$, $SE = 1.06$), $F(1, 157) = 7.985$, $p = 0.005$.

Two independent t-tests were performed to assess whether these discrepancies between groups for each technique were significantly different. These revealed that psychotherapy generalists showed a stronger adherence to psychodynamic techniques than sex therapy specialists ($t(157) = -2.904$, $p = 0.004$), and a lower adherence to CBT techniques than sex therapy specialists, $t(157) = 7.256$, $p < 0.001$.

9.1.3. Questionnaire Results: Controlling for Common Factors—Respondents' Use of Distinctive Psychodynamic and CBT Techniques

Figure 9.3 shows the mean scores for sex therapy specialists and psychotherapy generalists, on the summative scales for use of *distinctive* psychodynamic and *distinctive* CBT techniques. Respondents' scores for all psychodynamic and CBT questions were aggregated into two summative scales, with a possible value range of 8-40.

Figure 9.3: Mean Summative Scores for the Use of Distinctive Psychodynamic and Distinctive CBT Techniques By Practitioner Type



A two-way repeated measures ANOVA was performed on the factors of practitioner type (Sex Therapists versus Psychotherapy Generalists; between-subjects) and distinctive scales (Distinctive Psychodynamic Summative Scale versus Distinctive CBT Summative Scale; within-subjects). For the distinctive scales, a main effect was found, revealing that across all respondents, self-reported adherence to the distinctive psychodynamic techniques ($M = 25.42$, $SD = 5.91$) was higher than adherence to the distinctive CBT techniques ($M = 20.65$, $SD = 6.88$), $F(1, 157) = 71.581$, $p < .001$.

An interaction between the distinctive scales and practitioner type was also found, showing that the discrepancy between adherence to the subset of distinctive psychodynamic and distinctive CBT techniques was greater within the psychotherapy generalist group ($M = 27.55$, $SD = 5.59$; $M = 16.77$, $SD = 5.76$ respectively), than the sex therapists group's adherence to the subset of distinctive psychodynamic ($M = 23.69$, $SD = 5.62$) and distinctive CBT techniques ($M = 23.78$, $SD = 6.09$), $F(1, 157) = 74.038$, $p < .001$. This suggests that psychotherapy generalists were more discriminant in their adherence to the distinctive technique

subsets. A main effect of practitioner type was found, where sex therapists (M = 23.74, SE = 0.45) showed higher levels of adherence to both technique sets than psychotherapy generalists (M = 22.16, SE = 0.50), $F(1, 157) = 5.516$, $p = .02$.

Two independent t-tests were performed to assess whether these discrepancies between groups for each subset of distinctive techniques were significantly different. These revealed that psychotherapy generalists showed a stronger adherence to the distinctive psychodynamic techniques than sex therapy specialists ($t(157) = -4.313$, $p < .001$), and a lower adherence to the distinctive CBT techniques than sex therapy specialists, $t(157) = 7.392$, $p < .001$.

It would be important to note that the difference between sex therapy specialists' self-reported use of the distinctive psychodynamic methods and CBT methods is not statistically significant, $F(1, 87) = .013$, $p < .908$.

Table 9.1 and 9.2 illustrate the mean results for respondents' use of the techniques included in the distinctive psychodynamic and distinctive CBT technique scales respectively, indicating the frequency and percentage of respondents who report using each technique on a five point Likert scale ranging from "not at all" to "to the maximum possible degree".

Table 9.1
Use of Distinctive Psychodynamic Techniques showing frequency of endorsement and related percentage for all questionnaire respondents, sex therapy specialists (ST) and psychotherapy generalists (PG)

	Frequency (All)	Percent (%)	Frequency (ST)	Percent (%)	Frequency (PG)	Percent (%)
Discuss fantasies/dreams						
Not At All	14	8.8	8	9.1	6.0	8.5
Somewhat	46	28.9	31	35.2	15.0	21.1
Moderately	49	30.8	29	33.0	20.0	28.2
To a Significant Degree	39	24.5	16	18.2	23.0	32.4
To the Maximum Possible Degree	11	6.9	4	4.5	7.0	9.9
Total	159	100	88	100	71	100
Illustrate resistance to treatment						
Not At All	30	18.9	15	17.0	15	21.1
Somewhat	45	28.3	30	34.1	15.0	21.1
Moderately	47	29.6	22	25.0	25.0	35.2
To a Significant Degree	30	18.9	16	18.2	14.0	19.7
To the Maximum Possible Degree	7	4.4	5	5.7	2.0	2.8
Total	159	100	88	100	71	100
Examine unconscious thoughts/feelings						
Not At All	14	8.8	10	11.4	4.0	5.6
Somewhat	25	15.7	21	23.9	4.0	5.6
Moderately	40	25.2	28	31.8	12.0	16.9
To a Significant Degree	54	34	19	21.6	35.0	49.3
To the Maximum Possible Degree	26	16.4	10	11.4	16.0	22.5
Total	159	100	88	100	71	100
Discuss therapeutic relationship						
Not At All	20	12.6	16	18.2	4.0	5.6
Somewhat	50	31.4	31	35.2	19.0	26.8
Moderately	41	25.8	24	27.3	17.0	23.9
To a Significant Degree	36	22.6	14	15.9	22.0	31.0
To the Maximum Possible Degree	12	7.5	3	3.4	9.0	12.7
Total	159	100	88	100	71	100
Draw attention to unacceptable feelings						
Not At All	5	3.1	3	3.4	2.0	2.8
Somewhat	15	9.4	10	11.4	5.0	7.0
Moderately	36	22.6	29	33.0	7.0	9.9
To a Significant Degree	74	46.5	33	37.5	41.0	57.7
To the Maximum Possible Degree	29	18.2	13	14.8	16.0	22.5
Total	159	100	88	100	71	100
Focus on feelings of guilt						
Not At All	25	15.7	17	19.3	8.0	11.3
Somewhat	53	33.3	37	42.0	16.0	22.5
Moderately	42	26.4	21	23.9	21.0	29.6
To a Significant Degree	30	18.9	10	11.4	20.0	28.2
To the Maximum Possible Degree	9	5.7	3	3.4	6.0	8.5
Total	159	100	88	100	71	100
Work to resolve internal conflicts						
Not At All	5	3.1	3	3.4	2.0	2.8
Somewhat	21	13.2	20	22.7	1.0	1.4
Moderately	30	18.9	20	22.7	10.0	14.1
To a Significant Degree	76	47.8	37	42.0	39.0	54.9
To the Maximum Possible Degree	27	17	8	9.1	19.0	26.8
Total	159	100	88	100	71	100
Examine earlier formative experiences						
Not At All	3	1.9	2	2.3	1.0	1.4
Somewhat	11	6.9	9	10.2	2.0	2.8
Moderately	33	20.8	18	20.5	15.0	21.1
To a Significant Degree	82	51.6	45	51.1	37.0	52.1
To the Maximum Possible Degree	30	18.9	14	15.9	16.0	22.5
Total	159	100	88	100	71	100

Table 9.2
Use of Distinctive CBT Techniques showing frequency of endorsement and related percentage for all questionnaire respondents, sex therapy specialists (ST) and psychotherapy generalists (PG)

	Frequency (All)	Percent (%)	Frequency (ST)	Percent (%)	Frequency (PG)	Percent (%)
Specific activities/tasks for outside session						
Not At All	10	6.3	2	2.3	8	11.3
Somewhat	33	20.8	7	8.0	26	36.6
Moderately	39	24.5	21	23.9	18	25.4
To a Significant Degree	45	28.3	31	35.2	14	19.7
To the Maximum Possible Degree	32	20.1	27	30.7	5	7.0
Total	159	100	88	100	71	100
Encourage new ways of behaving						
Not At All	4	2.5	0	0	4	5.6
Somewhat	13	8.2	3	3.4	10	14.1
Moderately	25	15.7	10	11.4	15	21.1
To a Significant Degree	82	51.6	46	52.3	36	50.7
To the Maximum Possible Degree	35	22	29	33.0	6	8.5
Total	159	100	88	100	71	100
Behave in a teacher-like/didactic manner						
Not At All	57	35.8	19	21.6	38	53.5
Somewhat	69	43.4	44	50.0	25	35.2
Moderately	23	14.5	15	17.0	8	11.3
To a Significant Degree	9	5.7	9	10.2	0	0
To the Maximum Possible Degree	1	0.6	1	1.1	0	0
Total	159	100	88	100	71	100
Use of sensate focus exercises						
Not At All	53	33.3	17	19.3	26	36.6
Somewhat	24	15.1	11	12.5	13	18.3
Moderately	28	17.6	15	17.0	13	18.3
To a Significant Degree	33	20.8	26	29.5	7	9.9
To the Maximum Possible Degree	21	13.2	19	21.6	2	2.8
Total	159	100	88	100	71	100
Use of intercourse prohibition						
Not At All	62	39	24	27.3	38	53.5
Somewhat	25	15.7	12	13.6	13	18.3
Moderately	23	14.5	13	14.8	10	14.1
To a Significant Degree	31	19.5	25	28.4	6	8.5
To the Maximum Possible Degree	18	11.3	14	15.9	4	5.6
Total	159	100	88	100	71	100
Use of directed masturbation						
Not At All	61	38.4	16	18.2	45	63.4
Somewhat	39	24.5	23	26.1	16	22.5
Moderately	19	11.9	14	15.9	5	7.0
To a Significant Degree	28	17.6	27	30.7	1	1.4
To the Maximum Possible Degree	12	7.5	8	9.1	4	5.6
Total	159	100	88	100	71	100
Use of precise & fixed time limits						
Not At All	88	55.3	40	45.5	48	67.6
Somewhat	35	22	25	28.4	10	14.1
Moderately	20	12.6	11	12.5	9	12.7
To a Significant Degree	10	6.3	8	9.1	2	2.8
To the Maximum Possible Degree	6	3.8	4	4.5	2	2.8
Total	159	100	88	100	71	100
Use of systematic desensitization						
Not At All	66	41.5	25	28.4	41	57.7
Somewhat	27	17	18	20.5	9	12.7
Moderately	27	17	17	19.3	10	14.1
To a Significant Degree	31	19.5	22	25.0	9	12.7
To the Maximum Possible Degree	8	5	6	6.8	2	2.8
Total	159	100	88	100	71	100

These data indicate that, in the treatment of their most recent male client, both respondent groups (sex therapy specialists and psychotherapy generalists considered together) use prototypical psychodynamic techniques, inclusive of common factors, to a greater degree than they use CBT techniques. This obtains for both sex therapy specialists and psychotherapy generalists, considered together (Figure 9.1), and when considering sex therapy specialists and psychotherapy generalists as distinct groups (Figure 9.2). It is also important to note that the divergence between psychotherapy

generalists' self-reported use of psychodynamic versus CBT techniques, is greater than the divergence between sex therapy specialists' self-reported use of psychodynamic versus CBT techniques. Data also indicate that, when considering their work with their most recent male client, psychotherapy generalists report using psychodynamic techniques to a greater degree than sex therapy specialists. Conversely, psychotherapy generalists may use CBT techniques less than sex therapy specialists do.

Similar findings hold for the use of distinctive psychodynamic and distinctive CBT techniques, as psychotherapy generalists report using distinctive psychodynamic techniques more than they use CBT; psychotherapy generalists also report using psychodynamic techniques to a greater degree than sex therapy specialists do, and psychotherapy generalists report using CBT techniques to a lesser degree than ST specialists).

There is, however, one notable divergence between sex therapists' reported use of distinctive psychodynamic techniques versus prototypical psychodynamic techniques. When considering prototypical techniques (inclusive of common factors), sex therapy specialists report using psychodynamic techniques to a greater degree that CBT techniques. However, when examining the distinctive technique scales, *there is no statistically significant difference in the degree to which sex therapists report using distinctive psychodynamic versus distinctive CBT techniques with their most recent male client*. Overall, these data suggest that the sex therapy specialists surveyed surveyed here are more cognitive behaviourally oriented than their psychotherapy generalist counterparts. Additionally, it is essential to note that sex therapy specialists report a highly balanced use of distinctive psychodynamic and cognitive behavioural techniques with their most recent male client.

To summarize the quantitative findings on sex therapy specialists' and psychotherapy generalists' self-reported use of prototypical and distinctive psychodynamic and CBT techniques*:*

- Considering the entire sample, self-reported use of *prototypical* psychodynamic techniques is higher than self-reported use of *prototypical* CBT techniques, in the treatment of respondents' most recent male client (figure 9.1).
- For both the psychotherapy generalist group and the sex therapy specialist group, use of prototypical psychodynamic techniques appears to be higher

than use of prototypical CBT techniques, though this discrepancy is greater for psychotherapy generalists (figure 9.2).

- Psychotherapy generalists' use of prototypical psychodynamic techniques appears to be higher than sex therapy specialists' use of prototypical psychodynamic techniques.
- Sex therapy specialists' use of prototypical CBT techniques appears to be higher than psychotherapy generalists' use of prototypical CBT techniques.
- Considering the entire sample, use of *distinctive* psychodynamic techniques appears to be higher than use of *distinctive* CBT techniques, in the treatment of respondents' most recent male client.
- Psychotherapy generalists' use of distinctive psychodynamic techniques appears to be higher than sex therapy specialists' use of distinctive psychodynamic techniques.
- Sex therapy specialists' use of distinctive CBT techniques appears to be higher than psychotherapy generalists' use of distinctive CBT techniques.
- Psychotherapy generalists' use of distinctive psychodynamic techniques appears to be higher than their use of distinctive CBT techniques (figure 9.3).
- *Sex therapy specialists' self-reported use of distinctive psychodynamic techniques is roughly the same as their self-reported use of distinctive CBT techniques (i.e. sex therapy specialists' self-reported use of distinctive CBT techniques is slightly higher than their self-reported use of distinctive psychodynamic techniques, but this difference is not statistically significant).*

9.1.4. Discussion of Results: Contemporary Use of Psychodynamic Practice in Sex Therapy

As stated in chapters 1 (introduction) and 4 (methodology), the overarching aim of this research project is to identify both how psychodynamic theories and techniques are currently used in sex therapy and how they may be used to the best possible effect. The first research question aimed to determine: *to what extent do psychosexual therapy specialists currently employ psychodynamic therapy techniques in treating men's sexual dysfunctions*? The questionnaire data on sex therapy specialists' and psychotherapy generalists' use of prototypical and distinctive psychodynamic and CBT techniques appear to support the hypothesis that sex

therapists use psychodynamic therapy techniques to a significant degree in treating men's sexual problems.

A quotation from an interview with McCarthy (who, as indicated in chapter 8, section 8.2.1., emphasizes that he himself does not work from a psychodynamic perspective) illustrates the significance of psychodynamic methods. When asked about the respective influence of different theoretical models in the sex therapy field, McCarthy states: "if you were to ask me: 'what is the theory that is most impactful?' It's still psychodynamic. It's not the traditional Freudian psychodynamic, but it is a psychodynamic approach" (McCarthy, research interview, 17/01/2013, transcript p. 12, lines 1-3). Both the quantitative data presented in section 9.1.2. and 9.1.3., and qualitative data presented throughout this dissertation, appear to support McCarthy's assertion that psychodynamic theory continues to exert a high level of influence over the theory and practice of psychosexual therapy.

Data presented in sections 9.1.2. and 9.1.3. suggest that—while sex therapy specialists may tend to use more cognitive behavioural techniques, and less psychodynamic techniques than their psychotherapy generalist counterparts—sex therapy is an inherently integrative discipline. The data indicate that psychodynamic theory and technique exert considerable influence over the sex therapy field. Relative to the general thrust of current research in sexology and sex therapy, these results are surprising, and may support the theory that sex therapists often use psychodynamic techniques implicitly, without identifying them as psychodynamic per se. Considering these data, there appears to be a disparity between the degree to which psychodynamic techniques are *used* in psychosexual therapy, and the degree of attention they receive in the research and clinical literature. In short, it appears there are psychodynamic techniques used by sex therapists that are underrepresented in the literature. Additionally, considering both the qualitative and quantitative data on sex therapists' use of psychodynamic techniques, it appears that psychotherapists often may not be aware of the genesis of the psychodynamic techniques and concepts they use, or the links between the theoretical traditions from which these concepts and methods are derived.

9.1.5. Psychodynamic Practice versus Cognitive Behavioural Therapy: A False Antithesis

Tables 9.3 and 9.4 (presented in appendices X and Y) outline the key themes and sub-themes on the use of psychodynamic, and psychodynamically-informed,

theory and techniques in the treatment of male sexual dysfunction, identified in the qualitative data from this study. In considering how these research interview data may complement or enhance the quantitative findings from the questionnaire, it is important to note that explicit hostility to psychodynamic psychotherapy, and especially Freudian psychoanalysis, is an evident theme within a number of the research interviews. Excerpts from two interviews with leading sex therapists, illustrate this point. One of these interviewees describes psychoanalytic practice as "antiquated," and psychoanalysis per se as "narcissistic self-indulgence". From this interviewee's perspective, the term "psychodynamic" has become too nonspecific, "a trash-basket for so many different things that we have to get more specific about a methodology". As this dissertation has emphasized, evidence from this research project appears to support the position that psychodynamic practices are poorly understood, and remain largely unexamined in contemporary sex therapy research. Consequently, the image of psychodynamic theory as a "trash basket" may reflect the lack of clear and methodologically rigorous studies—either clinical or theoretical—on the place of psychodynamic methods in sex therapy, in addition to the wide variety of techniques and schools that are considered under the wider banner of "psychodynamic practice"(Gabbard, 2005; Shedler, 2010). In this respect, the paucity of relevant current research appears to accord with the findings of this study, and may indicate that psychodynamic methods are neither well understood, nor explicitly and methodically implemented on a large scale, in contemporary sex therapy.

The second interviewee, who works from an existentialist framework, stresses the importance of insight and awareness in the psychotherapy process, but holds that psychodynamic psychotherapy is unduly authoritarian, stating,

> in psychodynamic or psychoanalytic…you get the interpretation spoon-fed to you by the analyst, and then you can either reject it or take it in, and if you reject it then the analyst deems you as resistant, because the analyst has all the power. I mean, it's such horseshit.

In both instances, the condemnatory view of psychodynamic/psychoanalytic practice is expressed in adamant terms, and may reflect a common antipathy towards psychodynamic practice, which frames psychoanalytic and psychodynamic techniques as obsolete, authoritarian and perhaps ineffectual. However, published research suggests that later therapeutic schools—including existential psychotherapy, which has explicit roots in psychodynamic practice (Yalom, 1980)—are often

strongly influenced by psychodynamic theory (Cortina, 2010; Gabbard et al., 2012; Shedler, 2010; Strupp, 1992). The data from this study suggest that both sex therapists and psychotherapy generalists working in the treatment of male sexual dysfunction use insight-oriented techniques to a significant degree, and that this orientation may in fact have implicit psychodynamic roots. In short, the ostensive hostility to psychodynamic practice amongst some sex therapists may reflect a conflation of psychodynamic psychotherapy with a particular version of early classical psychoanalysis, and, as stated above, it appears practitioners may often be unaware of the genesis of some of the techniques they use that are linked to, or drawn from, psychodynamic theory and practice.

A number of other interviewees take a more attenuated approach to the use of psychodynamic techniques, and the integration of cognitive behavioural and psychodynamic methods. For instance, Daines, who self-identifies as an integrative practitioner, emphasizes the utility of psychodynamic methods within a multi-faceted intervention model (described in chapter 5)(research interview, 31/03/2013; Daines & Hallam-Jones, 2007; Daines & Perrett, 2000). An important aspect of this framework is the prospect of explicit and protocol-driven (rather than ad hoc) integration of techniques from divergent schools. As discussed in chapter 5 (section 5.4.4., and tables 5.2 and 5.3 in appendices I and J) qualitative data reveal a widespread perception that an integrative treatment protocol that includes both psychodynamic and cognitive behavioural elements can offer greater therapeutic power than mono-modal interventions. As Openshaw states, "I would want to have both [psychodynamic and CBT techniques] available to me" (research interview, 26/02/2013, transcript p. 4, line 29). The choice of using cognitive behavioural or psychodynamic techniques, she emphasizes, is contingent on a number of logistical factors. In her view, however, the primary determinant is:

> what the client is trying to achieve. If the client wants a fix, now, in the here and now, I would probably use CBT techniques…I can work in the here-and-now with the presenting problem, or I can go back and look at root cause. So, part of what I would start with is: what the client wants to achieve as a result of the therapy…I might say: ok, well, yeah, I can do cognitive behavioural work to fix it, but if we get to a block we may have to go back, in order to understand more, in order to go forward. So certain conditions I think I can treat much better if they want a solution now…But in terms of their focus, their focus may want to shift to understanding. So how I decide, really, is

> based on what I'm hearing them say to me about what they want to do. The other thing that will influence where I go is how much they can afford. Because if I've got six sessions, or twelve sessions, which it might be if I was working for the [National Health Service], or I've got an indefinite number of sessions, it absolutely affects what I'm going to open up and not open up (Openshaw, research interview, 26/02/2013, transcript p. 3, lines 29-46, p. 4, lines 1-4).

A number of factors, then, appear to inform the development and implementation of a stepwise, psychodynamically-informed protocol for the treatment of sexual dysfunction. These include:

- The client's clinical goals,
- The presentation and aetiology of the dysfunction or sexual problem
- The development of the treatment process, including the possible emergence of blocks, defences, or resistances to treatment,
- Insufficient treatment outcomes through work with immediate factors, and
- Treatment context and available resources (including number of sessions, and skills and training of the clinician).

An treatment protocol of this nature would likely be implemented within a psychotherapeutically integrative framework; data in this study indicate that a 'sectarian' or 'monistic' view, which defines methodological schools as exclusive (Karasu, 1986; Trijsburg, Colijn, & Holmes, 2005) is uncommon amongst sex therapists, a fact supported by extant research (Althof, 2010b). As illustrated throughout this dissertation, theoretical integration appears to be standard practice for both psychotherapy generalists and sex therapy specialists in their work with male clients.

It is also important to note the natural methodological overlap between psychotherapeutic schools. This research supports the conclusion, as identified in sections 9.1.1-9.1.2 above, that relatively few techniques are exclusive to one treatment school or another, and that even techniques considered 'prototypical' of one psychotherapeutic model may in fact serve as common factors, used across therapy systems. Consequently, questionnaire and interview data alike support the interpretation that—in the psychotherapeutic treatment of male sexual problems—integration is not an artificial combination of methodologically discrete elements. Rather, it appears that integrative practice often results from the natural overlap of techniques across modalities. A technique that is prototypical of psychodynamic

practice may also be a crucial element of other therapeutic models, including CBT-based models.

It must be emphasized that this research—which aims to identify the prototypical psychodynamic methods used in the sex therapy field—does not seek to plant a proverbial flag in a certain set of techniques and claim them for the exclusive (i.e. 'sectarian') use of psychodynamic practitioners. Instead, identifying prototypical psychodynamic methods used in the treatment of male sexual problems may serve to: illustrate what unique contributions psychodynamic theory might make to sex therapy, differentiate the implicit versus explicit use and integration of psychodynamic frameworks, and lay the groundwork for evaluating the ways in which explicit integration strategies for psychodynamic concepts might enhance psychotherapy outcomes. In these respects, a number of unique contributions of psychodynamically-informed theory/practice are apparent in the data from this study, including:

- focus on unconscious factors/processes,
- emphasis on providing the client with new insight (especially insight into unconscious factors in the sexual problem, and/or its relational context),
- a framework for conceptualizing the importance of repression as an aetiological/contributing factor in sexual problems (especially as linked to social constructionist theory, and examination of socio-cultural factors),
- attention to the distinction between immediate and deeper factors in the client's problem,
- focus on the importance of the clinical relationship,
- identifying and working with defences and resistances
- the importance of examining early life experiences, developmental factors and the client's family of origin, especially in light of their influence on current sexual and relational functioning.

Additionally, data indicate that theoretical and clinical models with roots in the psychodynamic tradition—especially attachment theory, and mentalization-based therapy—may be of significant value to contemporary sex therapy practice (Allen et al., 2008; Bateman & Fonagy, 2012; Berry & Berry, 2013b; Clulow, 2009; Diamond et al., 2011).

A number of treatment practices, grounded in the psychoanalytic and psychodynamic tradition, may serve to illustrate the natural overlap between these methodologies. Research has indicated, for instance, that a variety of psychotherapy

frameworks, including cognitive behavioural therapy, contribute to healthy mentalizing (Björgvinsson & Hart, 2006), and that mentalization-based techniques may be implicitly or explicitly included within a range of therapy systems (Allen, 2008a; Bateman & Fonagy, 2012; Fonagy et al., 2011). In the sex therapy field specifically, researchers are currently testing the theory that sensate focus exercises—widely recognized as a cognitive behavioural therapy intervention—might work to influence the client & his partner's attachment styles (Pacey, personal communication, May 29, 2013). In light of these findings, it is a primary conclusion of this study that, in the realm of psychosexual therapy, the apparent antithesis between cognitive behavioural- and psychodynamic therapy is a false one. Data from this study indicate that, given the predominantly integrative nature of clinical practice in the contemporary sex therapy field, the contemporary and prospective future use of psychodynamic techniques in sex therapy may best be considered within this integrative frame.

9.2.1. Contemporary Use of Psychodynamic Practice in Sex Therapy: Implicit Versus Explicit use of Psychodynamic Techniques

The second guiding research question for this project was: *how are psychodynamic techniques best integrated into the treatment of men's sexual dysfunctions?* Data support the conclusion that the development of such an integrative protocol must take account of the differentiation between explicit and implicit use of techniques, and explicit and implicit forms of theoretical integration. Significant extant research has established the clinical utility and efficacy of cognitive behavioural sex therapy techniques (Bancroft, 1977; Bulow, 2009; McCabe et al., 2010; Simopoulos & Trinidad, 2013; van Lankveld, Everaerd, & Grotjohann, 2001). Additionally, while the body of published research on the contemporary use and efficacy of psychodynamic methods in the treatment of male sexual dysfunction is negligible, the data from this research project appear to support the hypothesis that psychodynamic methods are both widely-used and widely seen as efficacious by sex therapy specialists and psychotherapists alike. The data also suggest that integration of these models may already be commonplace, though largely implicit, in the treatment of male sexual dysfunction. Consequently, the inclusion of psychodynamic and cognitive behavioural techniques within an integrative sex therapy model appears well supported by the research data gathered in this study. An emergent

question is: how might a procedural model of psychodynamic and CBT integration in the treatment of sexual dysfunction be developed, and what might it look like?

While further research is warranted, to distinguish how such an explicit integration protocol may be formulated, it is important to note that data in this study also point to the limitations of implicit integration. A comparative analysis of questionnaire data and interview data presents a complex and varied picture of how psychodynamic methods are currently used by sex therapists. A recurrent theme in the data was the ad hoc nature of psychodynamic interventions and, as noted, data suggest that psychodynamic methods are used to a significant degree, but that this use is largely implicit, and inconsistent between practitioners and for individual practitioners with different clients and across time. Evidence of methodical, explicit procedures for implementing psychodynamic methods in the treatment course is very limited.

Data within this study, and outside research and clinical literature, point to the limitations of implicit integration (Jones-Smith, 2011), and to the advantages of explicit and intentional theoretical integration in clinical psychotherapy practice (Brooks-Harris, 2008; Shoben, 1962). Assessment of the data from this study suggests that the use of an implicit, rather than explicit or procedure-driven, framework for the integration of psychodynamic techniques implies a number of concerns, including:

- possible limitations in the practitioner's understanding of the underlying theoretical framework,
- possible limitations in the practitioner's knowledge of related and complementary techniques that might be used,
- hindrance of the development of evidence-based practice, as implicit integrative practice does not facilitate research studies or clinical trials.

Limitations in the practitioner's theoretical knowledge, and scope of understanding of psychodynamic psychotherapy techniques, may stem from the fact that psychodynamic theories and techniques are largely learned informally, and intermittently, through professional development activities (rather than through sustained professional training), however more research is needed to determine where and how integrative therapists learn to implement psychodynamic methods. Overall, the data indicate that the pervasive implicit orientation to the use of psychodynamic methods training is informed by the wide variegation of clinicians' training.

Though this is an under-researched area, current clinical literature suggests the importance of implicit theories, alongside explicit theories, in determining the methodology and theory of change that underlie psychotherapists' work. Attention to implicit theories within integrative psychotherapy is supported by the argument that,

> implicit theories are not simply noise getting in the way of the real, formal or explicit theory. The study of implicit therapist theories may shed some light on therapist variability that may exist either independently of theoretical orientation or alongside it. There may be great similarity between therapists regardless of their theoretical orientation because all share a common implicit theory system that interacts with the explicit theory (Jones-Smith, 2011, p. 603).

The data presented here may help illustrate such a similarity between sex therapists, in the use of implicit psychodynamic theories of aetiology and use of psychodynamic techniques—in particular psychodynamically-informed theories of attachment. As Jones-Smith further argues, "therapists' implicit theories may be conscious, preconscious, or unconscious" implying the crucial emergent question: "how are their implicit theories of psychotherapy different from their espoused or explicit theories?" (Jones-Smith, 2011, pp. 601, 603). As stated above, data support the hypothesis that sex therapists often ascribe to psychodynamic theories, and utilize psychodynamic techniques implicitly, sometimes unaware of the psychodynamic legacy of these methods/principles, prompting the question: what is the prospective value of making psychodynamic methods more explicit in the sex therapy field?

It has been argued that, as theory serves as a foundation for clinical practice, explicit, well-articulated and well-reasoned theoretical principles are an essential foundation for good clinical methodology. "Since theories are inescapable in the ordering of the data with which we work as counselors," Shoben writes, "it would seem important to hold them as explicitly as possible and to examine their influence on our judgment and on our professional conduct" (1962, p. 620). In a clinical manual on multi-theoretical integration, Brooks-Harris (2008) supports this interpretation, stating that the first principle for the integration of psychotherapy theories is that psychotherapy integration should be based on intentional, explicit choices.

This research project is predicated on the supposition that explicit inclusion of psychodynamic methods may be clinically beneficial in the treatment of male

sexual problems. Thus, this dissertation, in addition to describing the data from this study, which indicate that psychodynamic methods are significant—though largely implicit—factors in psychosexual therapists' work with male clients, aims to serve as a point of departure for the development of evidence-based protocols for the explicit inclusion of psychodynamic techniques within an integrative model of sex therapy. The following sections describe some of the key psychodynamic and psychodynamically-informed techniques and theories that appear as significant within the data of this study.

9.2.2. Contemporary Use of Psychodynamic Practice in Sex Therapy: The Role of the Unconscious

Whereas psychoanalytic psychotherapists may place the unconscious in a place of primacy in the therapy process (Gabbard et al., 2012; Higdon, 2012), it appears that sex therapists often work with the unconscious implicitly, and view it as one element of the clinical picture to be explored within a context of relational attachment, and current behaviours. This perspective is reflected by Levine, who states: "to me, the legacy of psychoanalysis is our interest in the individual developing over time" (research interview, 08/01/2013, transcript p. 5, lines 8-9). However, Levine cautions that an exclusive emphasis on unconscious factors that neglects the social and relational context of sexuality and sexual problems may often obstruct the realization of sex therapy goals. He states that "certainly there are unconscious factors in everybody's experience of sex and love" but these factors must be considered vis-à-vis the client's "biology, and their individual development—that is, their psychology, their interpersonal relationship, and their culture" (research interview, 08/01/2013, transcript p. 5, lines 14-15). This quotation illustrates an important theme, evident in the interviews—that unconscious factors form an important element of the clinician's conceptualization of the client, and work with the client, but that these factors are considered within an integrative, biopsychosocial framework.

As discussed in chapter 8, the unconscious role of—especially psychosocial—developmental processes in the aetiology of sexual dysfunction is widely considered significant. The qualitative data indicate the role of repression and suppression may be significant in engendering a critical inner voice, which imbues sex and sexual dysfunction with affective experiences of guilt, shame and anxiety (see especially section 8.5.2. above). Qualitative data emphasize the effect

of the internalized voices of forbidding parents, which are seen as strongly impacting the client's sexual identity, and capacity to derive enjoyment from sex. Hall suggests that sex is often imbued with shame, due to the internalization of an inner voice, emergent from childhood experiences, "often," she suggests, "shame is used by parents as a punishment, as a method of control. It's amazing how much parents can control a child just with a raised eyebrow, with a tut, with a disapproving sigh" (research interview, 18/04/2012, transcript p. 5, lines 6-8). The development and continued influence of the internal parental voice underscores the apparent importance of considering unconscious processes from within both a developmental and relational perspective when working with men's sexual problems.

9.2.3. Contemporary Use of Psychodynamic Practice in Sex Therapy: A Relational Perspective

This research project is grounded in a conception of sex and sexuality—whether problematic or trouble free (if sex is ever fully trouble free)—within a relationship framework. This relational orientation is supported by the data in this study, and encompasses multiple dimensions of sexuality, including:

- The client's relationship with a partner or partners,
- The client's relationship with the therapist,
- The client's relationship with self and the many internalized thoughts, feelings and values that come out of past relationships,
- Interpersonal relationships, as they are enacted and played out in the social world, and
- Fantasized relationships, as they are imagined and reimagined.

Moreover, the intersections between these relational dimensions may introduce important elements and complexities to the clinical picture. As one clinical researcher stresses, "it is often difficult to tease apart the maladjusted patterns of relating that gave rise to the sexual problem from those that developed as a consequence of it" (Meana, 2010, p. 104). As outlined in chapter 5 (esp. section 5.5), in order to conceptualize the sexual problem within its developmental and relational frame, many sex therapists emphasize the importance of integrating the partner into the sex therapy process in some manner, and quantitative evidence point to sex therapists' prevalent tendency to utilize a couple therapy context in working with men's sexual difficulties (table 5.3, figure 5.7 and figure 5.8).

Additionally, a psychodynamic practice that focuses on the client's relational style involves attending explicitly to the therapeutic client/therapist relationship (see table 9.1 above). Thus, attention to numerous relationships and relational factors—both specific to sexuality and sexual functioning, and more broadly—reflects a point of intersection between sex therapy and psychodynamically-informed theoretical models, especially attachment-theory-based psychotherapy, and mentalization-based-therapy. Working within the conceptual framework of relationship, two key concepts, which may be of particular value in conceptualizing sexual problems as they are worked on by psychosexual therapists, can be identified. These are: attachment theory, and 2) mentalization-based theory and practice.

Additionally, while the data suggest that client goals are predominantly subjective and client-specific, it is widely accepted that the attainment of many clients' objectives requires helping the client find new ways of engaging in sexual (and often in non-sexual) relationships, and new ways of thinking about and engaging with a partner physically. In many cases, these new ways of behaving both stem from, and contribute to, new ways of thinking and feeling about relationships, new ways of attaching to their partner or partners, and new ways of mentalizing about their relationship.

Thus, the data collected in this study suggest that two simple, and ostensively prevalent, aims in psychosexual therapy, which may help address the multiple dimensions of sexuality described above, are: 1) to help the client change his attachment style, and often to move towards a more secure attachment style, and 2) to help the client develop a capacity for more reflective understanding (i.e. mentalizing) about sexuality, sexual relationships, and sexual problems. These two considerations—the role of attachment, and the role of mentalization in the treatment of sexual problems—are addressed in the following sections.

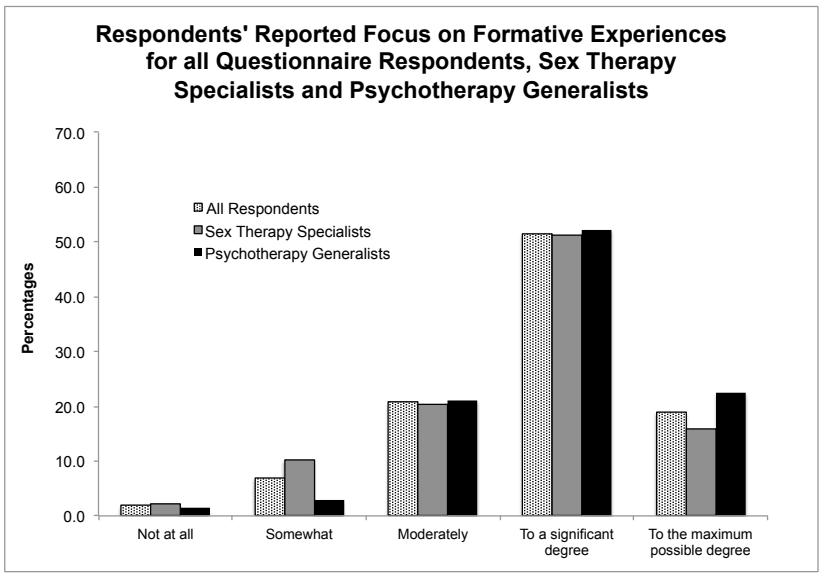
9.2.4. Contemporary Use of Psychodynamic Practice in Sex Therapy: Attachment Theory

Data suggest that attachment theory—an inherently interdisciplinary model of close human relationships influenced by psychodynamic theory (Cassidy & Shaver, 2008)—is a significant component of psychosexual theory and sex therapy that helps to account for the relational dimensions of sexual problems (Birnbaum, Reis, Mikulincer, Gillath, & Orpaz, 2006; Feeney & Noller, 2004; Johnson & Zuccarini, 2010). A substantial proportion of interviewees (44.1%) make explicit reference to

the role that attachment theory plays in their work (see tables 8.1 and 8.2), and attachment-related factors can be identified in virtually all of the interviews. This finding accords well with wider research emphasizing the increasing importance and influence of attachment theory in the work of sex and couple therapists (Clulow, 2009; Diamond et al., 2011; Stefanou & McCabe, 2012).

The increasingly significant apparent role of attachment theory in psychosexual therapy suggests the importance of early life factors (esp. attachment experiences) in the client's psychosexual and relational repertoire. Figure 9.4 indicates questionnaire respondents' answers to the question: "in the most recent case of male sexual dysfunction you treated, to what extent did you examine the patient's formative (earlier life) experiences as influencing current relationships/sexual functioning?" as measured on a five point Likert scale, ranging from "not at all" to "to the maximum possible degree".

Figure 9.4: Respondents' Reported Focus on Formative Experiences for all Questionnaire Respondents, Sex Therapy Specialists and Psychotherapy Generalists



Data indicate that respondents' level of focus on formative experiences, as influencing current relationships and sexual functioning, is high for all respondents, and comparably high for sex therapy specialists and psychotherapy generalists (refer also to table 6.4, above). The qualitative data accord with this finding, indicating that emphasis on early life, formative and attachment experience are primary themes, and that early life experiences are seen as highly influential over current sexual and relational functioning. Additionally, it appears that explicit and focused examination

of these themes with the client is seen as a key intervention strategy for many sex therapists. Thus, the data indicate that explicit attention to early formative experiences, and attachment experiences, may be a central theme/technique for psychotherapists and sex therapists.

Substantial research efforts have been dedicated to evaluating the role of attachment in adult romantic and companionate bonds (Hazan & Shaver, 1987, 1994; Hazan & Zeifman, 1999; Shaver & Hazan, 1993). Data from this study generally align with this body of outside research suggesting that attachment styles and behaviours, and their underlying cognitive and biological factors, have become an increasingly important focus in sex and couple therapy theory and practice, amidst the perception that attachment may have a significant bearing on sexual problems, and strategies for the resolution of these problems. The latter issue—how attachment theory can help clinicians to, first, conceptualize psychosexual relationships and, second, treat psychosexual difficulties—is of primary importance in this research project.

In the original definition, offered by Bowlby, attachment behaviour is defined as "any form of behaviour that results in a person attaining or maintaining proximity to some other preferred and differentiated individual" (1979, p. 129). Bowlby's approach is fundamentally *relational*, emphasizing the psychosocial aspects of attachment, an orientation that may make attachment theory particularly important to sex therapists, and psychotherapists and researchers attempting to understand sexuality within an interpersonal and relationship context (Diamond et al., 2011; Laschinger, Purnell, Schwartz, White, & Wingfield, 2004). Bowlby himself saw romantic/companionate relationships as the primary site of adult attachment, a view that has become a relative consensus amongst contemporary attachment-based psychotherapists (Bowlby, 1979; Holmes, 1993). In the adult attachment relationship, the romantic partner is believed to serve as a 'secure base', enabling work and exploration of the world, which are taken to be adult equivalents of the infant's experiences of play and exploration (for which the primary caregiver serves as a secure base)(Feeney & Noller, 1996).

Recent research examining adult attachment processes has begun to evaluate the role that attachment patterns play in adults' sexual and romantic relationships, and the implications that these patterns of attachment may have for the sex therapy process (Clulow, 2009; Diamond et al., 2011; Stefanou & McCabe, 2012). Adult attachment to a sexual or romantic partner—widely seen as the correlate of infantile

attachment to a primary caregiver—differs from infantile attachment insofar as the adult attachment relationship usually must integrate sexual behaviour and a sexual relationship.[36] Qualitative research data from this study, and external research, indicate that this integration—sometimes framed as an integration of "passionate" and "companionate" love schemas, a distinction discussed in chapter 8—is a focal point for sex and couple therapy (Eagle, 2011; Hatfield, Pillemer, O'Brien, & Le, 2008).

Although research on the links between attachment and sexual functioning is still in a relatively early stage of development, it is held that the development and maintenance of ongoing sexual relationships that successfully integrate companionate affection and sexuality often relies on secure attachment between the sexual partners (Ammaniti, Nicolais, & Speranza, 2007). Relatedly, it appears that many clinicians and researchers concur in the view that insecure attachment may often predict sexual dysfunction and sexual dissatisfaction (Brassard, Péloquin, Dupuy, Wright, & Shaver, 2012), and a systematic review of research from 1990 to 2011 indicates that anxious and avoidant attachment styles show a correlation to lower levels of sexual satisfaction, and higher levels of sexual dysfunction, across studies (Stefanou & McCabe, 2012).

Attachment theory holds that adults' attachment models and styles are powerfully influenced by both the attachment experiences of infancy, and by cognitive developments and learning experiences throughout the individual's life course (Ainsworth, 1989; Bowlby, 1979; Main, 1993). Consequently, while the enduring effects of infantile attachment are visible in an adult's attachment patterns, this influence is unpredictable and non-uniform, due largely to interceding life events. Cognitive growth throughout the life's course is seen as marked by the development of more advanced abstract and logical reasoning capacities, a higher level of metacognitive reflexivity and self-awareness, and a more sophisticated and nuanced sense of differentiation between self and other (Slade, 2008). In effect, this process involves a shift from the *experience* of attachment to a formal and abstracted *understanding* of attachment. Research suggests that the period of adolescence also entails a shift through which a parent or other caregiver—the de facto attachment figures in infancy and childhood—is supplanted by attachment to an intimately relatable peer (Allen, 2008b; Ammaniti et al., 2007). A crucial developmental

[36] The complex role of infantile sexuality within the infant's attachment relationship to a parent/caregiver has been discussed by Fonagy (2008a) and may be considered an important area for future research.

milestone, then, is the establishment of a romantic, companionate, or sexually-linked partner as the principal attachment figure in adulthood.

Of utmost importance is the fact that psychosocial aetiological factors may often be the outcome of an interaction between early developmental processes and current relationship factors (Althof, 2010b; McCabe et al., 2010; Montorsi, Adaikan, et al., 2010). Consequently, Levine states, sex therapists tend to be

> very interested in two subjects, after we get a sense of what the problem is. We are very interested in the development of the person, because we have an assumption that the dysfunction has something to do with the person's understanding of the world, understanding of him or herself, and what happened—what anxieties they have about attaching to another person…And if the problem is not lifelong, and it didn't antedate this relationship—if someone was sexually functional, say, for five years, and then developed a problem—then we want to explore the disappointments, and the tensions, and the dilemmas inherent in their relationship (research interview, 08/01/2013, transcript p. 2, lines 34-44, p. 3, line 1).

In evaluating, and working therapeutically with, attachment within the type of psychological and relational context that Levine describes, it is important to note that sexual behaviour and contact between the members of a couple may mirror attachment patterns and interpersonal dynamics outside of the bedroom, a phenomenon that Abse describes as "unconscious patterns of relating [that] have been satisfyingly mirrored in sexual activity" (2009, p. 105). This concept underscores two important elements. First, the intersection between attachment and sexuality must be considered within the wider relationship context, an issue emphasized by the qualitative and quantitative data of this study, and reiterated throughout this dissertation. Second, the patterns of relationship and sexual behaviour addressed in the therapeutic context—which implicate the client and his partner's love schemas, and inner working models of relationship—may operate at a largely unconscious level, meaning that the nexus between what occurs 'inside the bedroom' and what occurs 'outside the bedroom' implicates unconscious processes for both individuals, and between them.

Based on the literature in both the psychodynamic and sexology fields, and the data from this research study, attachment theory may be considered an important point of intersection between psychodynamic/psychoanalytic psychotherapy and sex therapy (Clulow, 2009; Yellin, 2007). This link may be illustrated by an interpretive

framework that situates 'intersubjectivity' at the centre of healthy sexual relationships (Diamond & Marrone, 2003; Holmes, 2007; White & Schwartz, 2007). Here, the concept of integrating attachment and sexual desire—erotic and affectional, passionate and companionate attraction—is central, and linked to the concept of an intersubjective relationship. "One can describe," Wingfield writes, "two different subsystems of sexuality: which I would broadly characterize as subject-object (one person), and subject-subject (two person psychology). One is a little dirtier, a little rougher, a subject and an object" (2007, p. 58). An intersubjective, or subject-subject relationship is construed as a securely attached relationship, marked by full mutual and interpersonal recognition, and characterized by an intimate interpersonal, sexual connection.

A functional intersubjective sexual relationship depends on a love schema, or inner working model of sexual relationship, that effectively integrates erotic and affectional components. Consequently, data suggest that encouraging the client to interpret, and shift, his inner working model of relationship may be a common, explicit or implicit, psychotherapeutic goal for sex therapists working within an attachment theory model. Underlying the concept of an intersubjective sexual relationship is the theory that insecure attachment styles, or difficult/unacceptable meanings that the individual may associate with attachment, may serve to impede sexuality. This theme—that there is a mutually enabling or inhibiting interaction between sexuality and attachment—is apparent in the interview data, and salient in the research literature (Brassard et al., 2012; Dewitte, 2012; Diamond et al., 2011; Stefanou & McCabe, 2012; Timm & Keiley, 2011). Clulow and Boerma suggest that insecure attachment may be associated with sexual and relational anxieties that impede the expression of sexual desire. "In contrast to partners who are securely attached and capable of intimate involvement with each other," they write, "couples who fear sexual desire in a loving relationship allow themselves to experience no exciting letting go in a passionate sexual encounter between them" (2009, pp. 88-89). This interpretation is supported by the qualitative data from this study, in which the concept that fear or avoidance of intimacy is an underlying causal factor in sexual problems is identified as a sub-theme amongst the unconscious aetiological factors underlying sexual problems (see tables 8.1 and 8.2).

The data in this study suggest that, not just attachment style, but the personal and relational meanings the individual associates with sexuality and attachment, are seen as crucial considerations in the psychotherapy process. The developmental

process the client has moved through in early life—especially attachment experiences in infancy and childhood—and the interaction between early developmental experiences and recent/current relationship experiences, contribute to the formation of love schemas, and internal working models of relationship (Hazan & Shaver, 1987).

The notion of the "internal working model", developed by Bowlby, and largely inspired by the work of Young (1964) and Craik (1943), is a dynamic mental model, in which past—especially developmental—experiences are viewed as key factors, which determine the individual's understanding of how the world (especially the social world) may work. Rather than a "map" (which implies a static and uni-dimensional representation of our world), the internal working model is seen as an evolving working representation of the social environment, and the individual's role therein, subject to change through experience (Bowlby, 1969: 80) The basic concept stipulates that individuals draw on a growing body of experience, to develop a cognitive model of both one's *own* world, and the world of *others*. The concept of love schemas extends this framework of social/interpersonal understanding into the sexual and romantic realm. Love schemas are conceptualized as romantic and sexual models of relationship that are heavily linked to attachment experiences in infancy and childhood (Choo et al., 1996; Hatfield & Rapson, 2010).

These relational schemas are seen as interlinked with a range of biopsychosocial response patterns, which contribute to—or detract from—sexual functioning. It is essential, however, to evaluate the role of mental processes, and the way the individual understands, or mentalizes, the relational processes involved in sexual contact with his partner. Desire disorders, for instance, as Clulow and Boerma suggest, "might be considered in relation to insecure patterns of attachment, where mentalizing…is likely to be limited or absent" (2009, p. 88). Data from this study offer a preliminary indication that deficiencies in mentalizing may often characterize the aetiology, or symptomatic configuration, of sexual problems, and exacerbate the effect of sexual problems within the relationship.

Consequently, qualitative data from this study and outside research suggest that examining the role that the client's attachment style plays in the sexual dysfunction generally requires examination of the client's sexual and relationship history, including early life experiences and parental relationships, and cognitive and affective processes more broadly (Diamond et al., 2011; Fonagy, 2008a; Resnick, 2012; Savage, 1999; Schwartz, 2007). In the following quote, one interviewee

describes a clinical strategy for working with attachment style in sex therapy practice:

> I look at their childhood… a big part of my work is to make the connection between attachment—how we learn to attach, how we—what our working model of relationship is, on the basis of what we witness in our parents. And in terms of how we become attached, how we become bonded to our primary caretaker, usually the mother, and then how we become bonded to the other parent, the father. And our expectations and how we learn to be a man or a woman. And then to recognize how that early experience resulted in a way we learn to be attached to another person, how we learn to be bonded to another person…all of that is part of sexuality. There's a tremendous amount of interplay between attachment, how we bond in childhood, and how we learn to be sexual (Resnick, research interview, 09/11/2012, transcript p. 7, lines 21-36).

A number of interviewees appear to agree with this interpretation, stating that the therapeutic implementation of attachment theory for sex therapy practitioners consists in helping the client to use a discussion of attachment style as a conceptual framework for interpreting the underlying cognitive, affective and psychosocial causes of sexual problems (Braun-Harvey, research interview, 15/11/2012; Kirkpatrick, research interview, 17/01/2013).

In this respect, a discussion of attachment style, and the relational patterns in which attachment style is enacted, may serve as a vehicle for helping the client to develop the capacity to mentalize the sexual relationship more effectively. This discussion may also encompass attention to inner working models of relationships, sexual schemas, and their roots in the individual's sexual history. It also appears that, for some psychosexual therapists, utilizing a discussion of attachment as the foundation for clinical work, involves first encouraging the client to

> get interested in this idea of attachment. That's the primary issue at the beginning. To have them begin to think about how they form connections with other people, and how they maintain them, and the defenses that they commonly rely on when proximity of distance in attachment is either too close or too far away. And those attachment styles are kind of indicative of how they monitor and regulate closeness and distance in relationships. And of course sexuality is an enormous part of closeness and distance in relationships, so we want them to understand how possibly their attachment

> style, and the way they experience emotions in attachment states, is driving their sexual behaviour as well (Braun-Harvey, research interview, 15/11/2012, p. 7, lines 1-10).

Consequently, it appears that for many clinicians, attachment theory is used as a means to help the client develop, or refine, their understanding of the interaction between sex and other relational factors, as they link to the current relationship and past experiences. In effect, this entails fostering reflective practice, and facilitating the development of the client's capacity to mentalize.

9.2.5. Contemporary Use of Psychodynamic Practice in Sex Therapy: Mentalization-Based Therapy

To recapitulate a number of key findings in this study: both survey data and questionnaire data suggest that within sex therapy, the development of client insight is seen as a core therapeutic goal. Additionally, a highly relational perspective is often taken by sex therapists, who aim to foster insight within the context of relationship. It is widely assumed that engendering insight about attachment style, and clarifying the client's understanding of the link between prior relationship experiences—including early attachment experiences—and current patterns of thought, feeling, and behaviour, within the sexual relationship, is a means to therapeutic progress. These goals suggest that enhancing the client's capacity to mentalize, within—and about—the sexual relationship, is one of the mechanisms by which psychotherapeutic change can occur. As such, evidence may support the use of mentalization-based therapy in the treatment of sexual dysfunction, a model discussed in this section.

The theory and practice of Mentalization-based therapy (MBT) is founded on research from evolutionary science, developmental psychology, attachment theory, psychotherapeutic clinical trials, and neuroscience (Fonagy et al., 2011). MBT holds that, phenomenologically, mentalizing is the cognitive and affective foundation for psychological (and psychosocial) well being. More than this, though, mentalization is seen as an essential psychological capacity, necessary for understanding our own minds and the minds of others. Mentalization, it is asserted, is no less than the "fundamental human capacity to apprehend our own and others' minds as minds" (Fonagy et al., 2011, p. 102). Jon G. Allen has famously described mentalization as "keeping mind in mind," (Electronic Article, retrieved on 10/04/2012), and Allen et al. have more recently expanded this description to include "keeping heart and mind

in mind" (Allen et al., 2008, p. 59). In treating sexual issues, it may be argued that mentalization-based therapy can be "grounded in the core principle of keeping body, heart and mind in mind," a reflection of the importance that many sex therapists place on the embodied experience of the client (Berry & Berry, 2013b, p. 14).

Mentalizing is seen as a psychological capacity defined by awareness (both explicit and implicit) of mental and emotional states in self and others, and the interaction that these factors may have with the embodied and relational experience of sexuality (Fonagy, 2008b). Within the MBT framework, this capacity is considered a key element of mental health and functioning. By definition, mentalizing requires a reflective understanding of the dynamic nature of thoughts and feelings; to mentalize is to understand thoughts and feelings in light of their intentionality and changeability. MBT holds that restoring or improving the client's ability to mentalize is a core objective of psychotherapeutic treatment (Fonagy et al., 2012a, p. 3). Specifically, MBT aims to restore and/or enhance the client's reflective functioning, increase volitional and intentional control over mental states and their associated behaviours, and instill tools to address symptoms and their interpersonal consequences (Bateman & Fonagy, 2012). These are posited as core goals in the psychotherapeutic treatment of a wide variety of psychopathologies, and may be fundamental to the successful treatment of men's sexual problems. It is also important to note that mentalization is seen as a core element of psychotherapy across modalities (Björgvinsson & Hart, 2006), and that the evidence from this study suggests that sex therapy, and psychotherapy that targets the client's sexual problems, may derive some of its therapeutic benefit from the effect it may have over the client's mentalizing.

Treatment/intervention informed by MBT aims to help improve the client's sexual problems as well as the distress they may cause. The role of mentalization in sex therapy is highlighted by sex therapists' objective of helping improve the client's psychosexual self-experience and sexual relationships, by increasing the client's understanding of their own mind and the minds of others (especially others with whom the client relates sexually). In this respect, as Skårderud and Fonagy write, "the essence of MBT is its systematic attentiveness to achieving such [reflective] understanding and, hence, improved affect regulation" (2012, p. 349). Within a MBT framework, treatment outcome for sexual problems may be measured by three key factors:

(1) quantifiable symptomatic improvement (reduction of the sexual

problem);

(2) change in the client's affect and cognition with respect to sexuality (especially, improved reflective functioning, and explicit mentalization about sexuality);

(3) improvement in the client's relationship(s), as manifested in increased interpersonal mentalization and mentalized affectivity in relationships.

As mentalization-based treatment is clinically grounded in the position that increasing mentalization and improving reflective capacity are core mechanisms of psychotherapeutic change, MBT aims to enable the client to mentalize the thoughts and feelings that predispose, precipitate, and perpetuate sexual problems and sexual dissatisfaction (Allen et al., 2008; Bateman & Fonagy, 2012; Wincze & Carey, 2001). This requires that the therapist and client explore the events and emotions that precede sexual behaviour, as well as the thoughts and feelings associated with the sexual problem.

In particular, the therapeutic process seeks to explore the interrelationships between the client's mind and the minds of others to whom the client relates, and the circumstances in which these interactions occur. Within psychosexual therapy, it may be hypothesized that a higher level of mentalization and reflective functioning can contribute to more effective communication within the sexual relationship, thereby encouraging the development or maintenance of a secure attachment, and intersubjective sexual relationship between partners. This theory fits with research findings that communication between partners is a mediating variable between attachment and sexual satisfaction in ongoing partner relationships (Timm & Keiley, 2011).

The development, or enhancement, of the client's capacity to mentalize may serve as a therapeutic mechanism for the integration of attachment and sexual dimensions of the couple relationship—an objective outlined in the previous section. "Mentalization," Diamond writes, "involves the capacity to imagine oneself and the other as both sexual and attachment objects and to integrate the disparate mental states involved with both experiences" (2011, p. 1). Within the realm of sexuality specifically, then, mentalization may serve to reinforce the client's understanding that sex, like attachment, exists within a relational context—a fact that is relevant for both sexual problems and sexual satisfaction/functioning. From this vantage point, "interpersonal reciprocity and mentalization are thus fundamental to the capacity to integrate affectional ties with sexual passion" (Diamond et al., 2011, p. 1).

Skårderud and Fonagy have introduced the concept of "embodied mentalizing" to "emphasize the corporeal aspects of the mentalizing process" substantiating the hypothesis, stated above, that in the psychosexual sphere mentalizing involves keeping body, heart and mind in mind (2012, p. 359). "By conceptually shifting from body to embodiment," they write, "the intention is to open up wider perspectives on the many possible roles of the human body in mental life and psychopathology" (2012, p. 359). This conceptual orientation may be of particular use in understanding the role of mentalizing in sex therapy, in which sexual problems are seen as intimately linked with, or experienced in, the body, and with the relationship between the client's body and another's body. "The presentation of sexual difficulties in a couple," Abse writes,

> is often located in a bodily dysfunction and the dysfunction (if not organic) can feel mysterious both to the couple and the therapist. In addition, both the couple and the therapist may find that these problems are often difficult to explore imaginatively. Loss of desire in one or both partners may not be accompanied by any easily accessible narrative (2009, p. 107).

Thus, the experience of embodiment, associated with sexual and attachment processes, is a site of multiple meanings for sex therapists and their clients—it is identified both as the site of sexual problems, and associated feelings including the biophysical manifestations of anxiety, guilt and shame, and also as the site of sexual pleasure, embodied connection with a partner, and physical intimacy.

9.3. The Place of Psychodynamic Practice in Sex Therapy: Summary of Findings

Data presented in chapter 9 illustrate the role of prototypical and distinctive psychodynamic psychotherapy techniques in the treatment of male sexual dysfunction. The quantitative similarities and differences between sex therapy specialists' and psychotherapy generalists' use of psychodynamic and CBT techniques are described. Overall, psychodynamic techniques appear to be an important part of the clinical work of both sex therapy specialists and psychotherapy generalists, although psychotherapy generalists report a higher level of adherence to psychodynamic practice. The distinction between implicit and explicit use of psychodynamic techniques is of particular importance, as it may help explain the paucity of literature on psychodynamic practice in the sex therapy field. Data here appear to support the hypothesis that psychodynamic techniques may be commonly used by sex therapists without being identified as such.

The chapter presented evidence that several key areas of psychodynamically-informed practice may be of particular importance for sex therapists, including focus on unconscious factors, the use of a relational perspective, integration of attachment theory into clinical practice, and the use of mentalization-based therapy techniques. Collectively, the data here indicate that psychodynamic techniques may indeed be a significant part of sex therapists' work, and that the psychodynamic principles highlighted in this chapter may be particularly influential and useful in sex therapists' work. In the following, concluding, chapter, the implications of these findings, their significance in the field, and directions for future research, are discussed.

CHAPTER 10. DISCUSSION OF RESEARCH, AND FUTURE DIRECTIONS

10.1. Summary of Research Results

This research project set out to determine whether psychodynamic psychotherapy concepts and techniques are used in the specialist treatment of male sexual dysfunction, asking: do sex therapists use psychodynamic techniques when working with their male clients? Based on the data gathered in this study, the answer appears to be a definitive "yes". In order to determine the role that psychodynamic techniques play in sex therapy specifically, sex therapists (n= 88) were compared to psychotherapy generalists (n=71), using a quantitative questionnaire. These groups were compared based on their self-reported use of prototypical psychodynamic and cognitive behavioural therapy techniques in treating their most recent male client. For both groups it was found that the self-reported use of prototypical psychodynamic techniques was *higher* than the self-reported use of CBT techniques, though this discrepancy was greater for psychotherapy generalists. Psychotherapy generalists reported using psychodynamic techniques more than sex therapy specialists, while sex therapists reported using CBT techniques more than psychotherapy generalists. Thus, the data suggest that while sex therapy generalists do use psychodynamic techniques, they are less psychodynamically inclined than their generalist counterparts.

It is important to note that, given the well-documented methodological overlap between psychotherapy modalities, many of the techniques deemed prototypical of psychodynamic psychotherapy or CBT may be construed as common factors/techniques, utilized across disciplines (Larsson et al., 2013; Luborsky et al.,

1985; Najavits, 1997, p. 1; Najavits & Strupp, 1994; Smith et al., 1980). Consequently, a sub-set of *distinctive* techniques—considered to be more distinctly and exclusively characteristic of each modality (psychodynamic and CBT)—was defined and assessed. As with the prototypical techniques, psychotherapy generalists reported using distinctive psychodynamic techniques more than sex therapy specialists did, while sex therapists reported using distinctive CBT techniques more than psychotherapy generalists did. A critical finding, however, was that *there is no statistical difference in the degree to which sex therapy specialists reported using distinctive psychodynamic techniques and distinctive CBT techniques*. This finding suggests that, when considering the techniques that are most characteristic of each methodology, not only do sex therapists use psychodynamic techniques to a considerable degree, sex therapists may use both psychodynamic psychotherapy and CBT to roughly the *same* degree, in their treatment of male clients.

The project also aimed to determine what is distinctive about sex therapy relative to psychotherapy more generally. It is important to note that the defining features of sex therapy have been widely contested in recent decades (Kleinplatz, 2003; Schover & Leiblum, 1994), with some leading researchers even questioning whether sex therapy is a distinctive discipline, or just a subset of psychotherapy/counselling (Binik & Meana, 2009). As such, one of the research aims of this project was to generate data on the primary practices in contemporary sex therapy and ascertain how psychodynamic and psychodynamically-informed methods fit within the field. To this end, an interview-based survey of sex therapists and subject experts (n=34) was conducted. Analysis of the qualitative data supported the conclusion that sex therapists commonly use psychodynamic techniques (alongside CBT techniques). However, the qualitative data indicate a related finding: *sex therapists' use of psychodynamic techniques is often implicit, and used within an integrative model in which techniques are chosen in vivo (rather than determined by a manual- or protocol-driven treatment process).*

In fact, the finding that sex therapists adhere primarily to an integrative model of treatment was salient throughout the data. It is interesting to note that some interviewees appear to construe "sex therapy" (as opposed to general counselling or psychotherapy) in accordance with a set of behavioural techniques that find roots in the work of Masters and Johnson (Masters & Johnson, 1963; Masters & Johnson, 1966; Masters & Johnson, 1970; Masters et al., 1982). However, the data from this study, and outside research, suggest that in practice, the work of sex therapists is

highly integrative both psychotherapeutically and in terms of the biopsychosocial model of integrative practice (Althof, 2010a; Althof, 2010b).

This research project was carried out with attention to the fact that, as stated at the outset of this dissertation, we live in a biomedical era, powerfully influenced by pharmacological therapies especially (i.e. the widely documented "Viagra revolution")(Bancroft, 2005; Grace et al., 2006; Tiefer, 2006). A focal consideration for this project, therefore, was the role of the *biopsychosocial model* in the work of sex therapists. Data suggest that sex therapists use the biopsychosocial model within their clinical practice to a significant degree and make greater use of the BPS model than their psychotherapy generalist counterparts. Consequently, it may be inferred that use of an integrative biopsychosocial approach is a distinguishing feature of the sex therapy specialization. In particular, while biopsychosocially integrative multidisciplinary facilities were identified by interviewees as an ideal, the use of multidisciplinary referral networks was seen as an essential means for biopsychosocial practice.

In addition to biopsychosocial integration, a number of other areas of integration were salient in the data. Psychotherapy integration—the eclectic or assimilationist inclusion of multiple models of psychotherapy—was seen as a core characteristic of sex therapy specialists' practice (Messer, 1992; Norcross & Goldfried, 2005; Norcross et al., 2005; Wampold, 2013). As stated above, data indicate that this integrative psychotherapy approach includes both prototypical and distinctive psychodynamic and CBT techniques to a comparable degree.

Another area of integration that may distinguish sex therapy from general psychotherapy exists at the structural level, and involves the inclusion of the client's partner (where the client is in a partnered relationship). For this reason, this dissertation explored the question: does it take two to tango (i.e. do sex therapists utilize a couple-counselling approach as a standard practice?)? Both the qualitative and quantitative data indicate that a couple counselling model is indeed standard, a finding that accords with the recent development of systemic sex therapy and the inclusion of systemic psychotherapy approaches across the sex therapy field (Hertlein, Weeks, & Gambescia, 2009; Hertlein, Weeks, & Sendak, 2009; Kleinplatz, 2009; Leiblum, 2007b). Data collected here establish that sex therapists use a couple counselling approach with their clients to a much greater degree than do their psychotherapy generalist counterparts.

What exactly are the conditions that sex therapists treat using this integrative model of practice? Data suggest that the diagnostic categories used in the sex therapy field are contested, challenged and subject to critical scrutiny. In particular, the American Psychiatric Association's standardized psychiatric diagnoses presented in the *Diagnostic and Statistical Manuals*, are identified by interviewees as problematic (2000, 2013). These diagnostic categories (which were used in this study as a general framework for understanding the psychosexual problems for which males may be treated) find provisional use as a shorthand model for communicating with clients and other health practitioners (i.e. those in a referral network). However, a number of interviewees emphasize that these categories are rooted in a simplistic, heteronormative model of sexual behaviour. Consequently, the risk that standardized diagnostic categories may label, stigmatize, or pathologize clients is highlighted (Barker, 2011a; Kleinplatz, 2012a).

Data show that a comprehensive sexual history taking—which often incorporates attention to early life and developmental factors—is widely considered standard practice for sex therapists in the assessment of clients' sexual problems. Evidence from both the questionnaire and interviews suggest that insight into unconscious and other psychodynamic factors (for both the clinician and the client) is seen as a goal of this assessment process. Consequently, data indicate that a tendency to focus—implicitly or explicitly—on unconscious and other psychodynamic elements is common in the assessment of clients' sexual problems. These psychodynamic elements encompass early life and developmental experiences, which are seen as consciously and unconsciously linked to the client's current sexuality and presenting sexual problems. Use of a longstanding assessment model, in which the aetiological factors underlying the client's sexual dysfunction are categorized as predisposing, precipitating, or perpetuating, appears commonplace. While this model was initially offered as a cognitive behavioural assessment framework (Hawton, 1982, 1985), interview data indicate that it is also used to classify psychodynamic factors, in particular unconscious causal processes.

An important apparent point of congruence between sex therapy and contemporary psychodynamic therapy consists in the high level of importance both models place on the therapeutic relationship and a relational model of psychotherapeutic practice. As Spurling writes,

> in the psychodynamic therapies there has been a shift in therapeutic stance away from the idea of power residing solely in the therapist and doing things

> to the client, towards the idea of the therapist listening to and being guided by what the client says (2009, p. 24).

Moreover, clinical guidelines suggest that the tendency to focus on the therapeutic relationship, and be "guided by what the client says" may also characterize the work of many cognitive behavioural therapists (Allen, 2006; Leichsenring et al., 2006; Westen, 2000), indicating that this may be a basis for congruence between, or integration of, contemporary psychodynamic and CBT practices in the sex therapy field.

This conceptualization of client-centred practice is apparent in the data from this study, which suggest that goal-setting and progress tracking are determined by the client's subjective assessment of what is sought from therapy, and what has been accomplished through therapy, alongside the clinician's measured assessment of what might realistically be attained. That is, interviewees widely emphasize that goal setting is a client-led, subjective process, and the therapist's role is largely to negotiate and monitor realistic clinical objectives with the client. A number of interviewees stress the use of a shifting case formulation in which the objectives of the therapy are apt to change as the client moves through the treatment process. Overarching this subjective, client-led, shifting case formulation, however, is an orienting framework, prominent in the qualitative data, in which pleasure, desire and intimacy are perceived as essential clinical goals (McCarthy & McCarthy, 2013; Metz & McCarthy, 2007). Within this critical framework, quantitative metrics of sexual 'success' (for instance, number of sexual encounters, duration of sexual encounter, or number of orgasms) are de-emphasized in favour of subjective pleasure and relationship satisfaction.

Conventional/normative standards of sexual behaviour are also contested by critical sex therapists who question the heteronormativity, mono-normativity, and limited acknowledgment of diversity that are seen to underlie traditional sex therapy work (Berry & Barker, forthcoming 2015). Critical sex therapy models, which focus on working with diverse and non-normative client groups, are a point of emphasis in this dissertation. The value of nonjudgmental acceptance, strongly endorsed by a majority of sex therapists, is seen as a foundation for critical sex therapy work. However, a number of sex therapists point out that general principles of beneficence and nonjudgmental acceptance must be supplemented by clear and effective strategies for working with diverse client populations. Core principles of critical therapy, identified in the data from this study include:

- The use of social constructionist theory, to acknowledge the diversity and uniqueness of client groups, and the influence of social factors on clients' experience of sexual identity, and sexual problems,
- The use of normalizing—a highly prominent technique in the data—which seeks to establish that both the client's identity and presenting problems are comprehensible and normal within the range of their experience,
- Horizontalizing, or situating diverse (especially non-normative) aspects of the client's identity within the wider 'horizon' of the client's experience, rather than fixating on these issues in the course of therapy (for example, fixating on a bi-sexual client's sexual orientation as the focal point of therapy, rather than one aspect of the client's identity),
- Acknowledging the fluidity of the client's identity,
- Affirming the client, and specific aspects of their identity (for instance sexual orientation or non-normative sexual practices), particularly in instances where experiences of prejudice have been a significant concern.

A prominent trait of critically-oriented sex therapy, indicated by the qualitative data, appears to be the emphasis reflective practice and reflective functioning (RF), for both the practitioner and the client (Stedmon & Dallos, 2009; Steele & Steele, 2008). While the practitioner's reflective practice is seen as an essential strategy for managing personal prejudice and remaining open to the unique experience of the client, the client's own reflective functioning is seen as a moderator of sexual functioning, meaning that increasing the client's RF is a core clinical goal.

Aetiologically, the data strongly suggest that sex therapy practitioners subscribe to a multi-dimensional view of causation. Simply put, most sex therapists appear to believe that sexual problems are created by numerous interrelating factors. Within the interlinking model of causal factors, the importance of early life and developmental experiences once again comes to the fore in both the qualitative and quantitative data. The influence of experiences within the family of origin is also emphasized as a key aetiological factor in many clients' sexual problems. Interviewees stress the influence of social and cultural factors—including restrictive or repressive messages about sex—in early life. This emphasis is linked to an unanticipated theme in the data: clinicians' tendency to highlight the detrimental impact that religion and religious upbringing often has on the client's sexuality.

Repressive experiences in early life and conflicting cultural messages about sexuality are seen as contributing to the development of several affective elements,

which many sex therapists consider fundamental to clients' sexual problems: *guilt, shame and anxiety*. The presence of anxiety in sexual problems is a mainstay in the sex therapy literature, and reducing anxiety has long been seen as a clinical goal when working with sexual dysfunction (Barlow, 1986; Bruce & Barlow, 1990; McCabe et al., 2010). However, the link between anxiety, guilt, and shame—as both psychological and embodied processes, determined by both conscious and unconscious factors grounded in early life—may reflect a new area of emphasis in the sex therapy specialization. Two psychodynamic aspects of the anxiety-guilt-shame triumvirate that bear particular emphasis are: the contribution of early life and family of origin experiences, and the unconscious dimensions of these psychoaffective processes.

For many therapists interviewed, the objective of increasing client insight extends to the client's understanding of the causal factors underlying their sexual problems. Ascertaining the cause of the sexual problem is widely seen as prerequisite to resolving the sexual problem (or otherwise attaining the client's goals). In this realm, a prominent psychodynamic theme is the concept that the sexual symptom may serve an unconscious meaning (the "function of the dysfunction" as one interviewee describes it, in a quote cited above)(Dunn, research interview, 29/01/2013). Illuminating the symptom's unconscious purpose, and the aetiological process by which it emerged, including early life and parental influences, appears—within both the qualitative and quantitative data—to be a central objective in many sex therapists' work, underscoring the utility of psychodynamic methods.

It is necessary to highlight again that the data indicate psychodynamic methods are used, to a significant degree, integratively, alongside cognitive behavioural and other techniques. Levine identifies a view of this integrative framework, which accords well with this evidence; he states,

> It is not so much that a psychodynamic approach is a method for therapy of sexual dysfunction and more that it is a way of listening, understanding, and asking questions that illuminate what is going on within the patient or the couple. Psychodynamic psychiatry is excellent for grasping development of individuals. It prepares clinicians to never lose sight of the internal life of the person as more behaviorally oriented clinicians do as they focus on behavior rather than feelings, conflicts, and personal considerations. The dysfunctions are so diverse that the treatment for dysfunction should not be presented as

psychodynamic vs. behavioral (Levine, personal communication, Jan. 12, 2013).

One of the primary conclusions of this study, apparent in this quotation, is that the distinction between psychodynamic and cognitive behavioural therapy may be a false antithesis. Within the integrative treatment framework that is currently prevalent in sex therapy, a fundamental objective is to help the client gain insight into:

- Relational context and (for attachment theorists) the role of attachment style
- Influence of developmental and early-life factors
- Implicitly, or explicitly, the role of unconscious factors and unconscious processes
- The interactions between cognitive and affective processes, vis-à-vis relational and sexual functioning (i.e. improved reflective functioning).

One of the main benefits of psychodynamically-informed techniques, whether used explicitly or implicitly, is to foster these types of insight.

A primary finding of this research, highlighted above, is the considerable contemporary importance and influence of attachment theory in the field of sex therapy. The implication of this finding is that the multidimensional aetiological pathway of sexual dysfunction is seen to include early life experiences that set the stage for specific (functional or dysfunctional) sexual schemas and inner working models of relationships. Within this model the internalization of restrictive, and arguably repressive, views of sex and sexual behaviour, impacts the client's sexuality and often contributes to sexual problems. The emergence of enduring guilt, shame and anxiety (both inherent and adventitious to sexuality) is seen as fundamental in this aetiology. Intervention, therefore, focuses on helping to generate insight and foster new and more satisfying ways for the client to engage in sexual and attachment relationships

Attachment theory is identified—along with mentalization-based therapy—as one of two psychodynamically-informed models that may be of particular use in sex therapy research and practice, based on the data from this study. Mentalization-based therapy techniques, which may often be used implicitly in sex therapists' work, have been described as a conceptual system that may further the common objective of fostering client insight into cognitive and affective content, especially in linking the client's thoughts and feelings with the relational and behavioural aspects of their sexuality and sexual problems (Allen et al., 2008; Bateman & Fonagy, 2012). Ultimately, the data from this study suggest that helping clients to understand how

they relate to others, both companionately and passionately, is fundamental to the work of sex therapy (Hazan & Shaver, 1987; Shaver & Hazan, 1993). Clarifying their inner working models, sexual and relational schemas, and the way their attachment style developed from early life onwards, the data suggest, is fundamental to this process.

It is important to qualify these findings, and their implications, by noting some of the main limitations of this study. In particular, it is necessary to acknowledge that the findings may have been influenced by the nature of the survey sample, and the limitations of the sampling frame. While this survey evaluated the self-reported practices of psychosexual therapy specialists and psychotherapy generalists, the work of CBT specialist practitioners was not focused on. Hence, the extent to which principally CBT-oriented therapists would adhere to the prototypical therapy techniques evaluated here is largely unknown, and it is certainly possible that psychotherapists registered specifically with CBT specialist organizations would show lower adherence to the prototypical psychodynamic techniques measured here than the individuals surveyed in this research project. The specific limitations of the questionnaire and interview, respectively, are examined at greater length below (sections 10.3.1 and 10.3.2). First, however, the principal implications of this survey are discussed.

10.2. What does this Mean? The Implications of this Study

The primary finding of this study is that sex therapists do use psychodynamic techniques. In fact, as stated, the data suggest that they may use psychodynamic techniques as much as they use CBT techniques. The implication of this finding is that further research on the contemporary role of psychodynamic practices in the sex therapy field is warranted, and that, according to the data from this study, future research may be developed on the hypothesis that psychodynamic methods are already used to a significant degree.

The data gathered here indicate that a stepwise procedural or protocol-driven approach to integrating psychodynamic and CBT elements could realistically be developed (and indeed, it appears that such a model is already taught in the UK, at training organizations like TCCR and RELATE). Historically, models of this nature often move from immediate causes towards ‘deeper’ elements, contingent on a variety of psychodynamic factors, including resistance and defenses. These models follow a stepwise theory of psychotherapeutic intervention, developed by Kaplan,

(Kaplan, 1974b, 1979). However, the evidence suggests that a straightforward return to Kaplan's stepwise model of theoretical integration—in which psychodynamic methods are implemented to address "deeper" unconscious factors when behavioural interventions prove insufficient or resistances emerge—is not sufficient. Instead, new integrative models must account for several factors in the clinical milieu and within the current psychotherapeutic field, including the advancement of attachment theory and, prospectively, mentalization-based theory.

First, as discussed in section one (chapters 1-3) and in chapter 5, models of theoretical and technical psychotherapy integration must be considered within the wider framework of biopsychosocially integrative practice. In this respect, treatment algorithms, whether sequential or fully-integrated, must account for medical screening and the integration of multidisciplinary treatment team members (Daines & Hallam-Jones, 2007). Secondly, models for psychotherapy integration must evaluate the divergence between implicit and explicit theoretical integration (as discussed in chapter 8) and determine whether technical eclecticism or theoretical assimilationism (as discussed in chapter 5) is a more viable strategy for integration. More research is needed in this area to assess the efficacy of eclecticism relative to assimilationism, and implicit integration relative to explicit integration, although the data gathered in this research appear to support the use of explicit integrative practice. Third, contemporary models of psychotherapy integration that aim to include psychodynamic theory/techniques alongside other sex therapy methods must account clearly for the role of attachment theory.

Consequently, further research on the role that attachment and mentalization-based therapy may play in the sex therapy field is needed. The application of attachment-based theory in the field of sex therapy is in a relatively nascent stage of development. In particular, work is needed to determine how research from the varied areas of attachment research may be translated into clinical practices in the treatment of sexual dysfunction. The application of mentalization-based theory in the treatment of sexual dysfunction is even more limited. Despite the negligible connection between mentalization research and sex therapy, early studies indicate this as a promising area for integration and further focused research (Berry & Berry, 2013b; Fonagy, 2008a).

Another important finding is that sex therapists are keenly aware of the biopsychosocial model. Yet, as stated in chapter 3, researchers have argued that clinicians' attention to the biopsychosocial model in the sexual health field may often

be rhetorical, rather than applied (McCarthy & McDonald, 2009a). Consequently, while the data here suggest that biopsychosocial integration is primarily developed through the use of referral networks, further research is needed to determine how biopsychosocial and integrative practice can be effectively optimized.

10.3. *The Limitations of this Study*

The first and foremost limitation of this survey is the focus on male clients exclusively, rather than all clients. This choice was taken in order to ensure a manageable scope for the research study. However, after the collection of questionnaire data, it was determined that a wider perspective, not exclusive to male clients, would have been feasible. The second notable limitation consists in the fact that this research focuses solely on clinicians. This choice also was taken to ensure a manageable scope. Future research, which takes clients as research subjects, would be worthwhile. There are also several limitations specific to the questionnaire and interview methodology, which will now be discussed.

10.3.1. Questionnaire Limitations: Sampling Frame and Sampling Methodology

In considering the inherent limitations specific to the questionnaire methodology, it must be acknowledged that this type of instrument relies on subjective measurement and self-report, which creates a risk of response bias. Research participants may misjudge the question, or misremember their clinical experience. Specifically, as this questionnaire asks about the (approximated) frequency with which respondents treat particular dysfunctions and use particular therapy techniques, it is susceptible to inaccurate estimations. Additionally, research subjects may have a vested interest in a particular methodology and may try, intentionally or unintentionally, to answer in a way that reflects their preference (i.e. respondents who endorse psychodynamic therapy may try to affirm that they use psychodynamic techniques primarily, or even to the exclusion of other techniques).

At the structural level, certain logistic limits apply to the survey as well. As with any survey that samples a limited proportion of a studied population (see sampling methodology section), it is necessary to be cautious in generalizing to entire populations of psychotherapists or sex therapists. Respondents may disproportionately represent specific subgroups within their broader fields, or they may possess particular traits that make them more apt than others to respond to the questionnaire, introducing sampling bias. Also, the questionnaire targets only

therapists, and while it assesses clinicians' impressions of the therapeutic process, as stated above, patients' views are excluded.[37] Additionally, this research does not include empirical treatment results measures (i.e patient testing), which were simply beyond the scope and resources of this project.

Inherent limitations or concerns (especially due to bias, or instrumentation problems) must be acknowledged and accounted for in order to ensure the study's validity. By identifying and acknowledging limitations, the researcher can exercise a certain degree of control over them, in order to preserve the study's integrity (Langdridge and Hagger-Johnson, 2009: 133). The primary limitation of this data collection method consists in the fact that it reflects respondents' *perceptions* of the therapeutic process (rather than empirical observation and measurement of the clinical process). In extrapolating from questionnaire data, the research is careful to acknowledge that these data do not provide purely objective insight into clinical reality, but rather provide information about clinicians' self-reported, subjective impressions of their clinical practice. It is important to note that different professionals (i.e. psychologists as compared to psychiatrists as compared to clinical counsellors etc.) may differ in the degree to which they both take a biopsychosocial approach to treatment, and use psychodynamic methods, etc. While the data collected here allow for some analysis of these differences, further examination of the between-groups variance for different types of professionals is warranted.

It is also necessary to consider the representativeness of the sample, particularly in light of the low response rate. As Shaughnessy et al. state, "a sample is representative of the population to the extent that it exhibits the same distribution of characteristics as the population" (2006, p. 149). The first threat to representativeness in this study consists in the possibility of selection bias, "which occurs when the procedures used to select the sample result in the overrepresentation of some segment of the population or, conversely, in the exclusion or underrepresentation of a significant segment" (Ibid. p. 150).

One of the limitations of the sampling frame is the respondents' geographical locations. Table 10.1 indicates respondents' countries of practice.

[37] In the research design process, the possibility of administering a comparable questionnaire to patients, to gauge their impressions of the clinical process, was considered. Ultimately, the survey's resource limitations necessitated that the survey focus on clinicians only. This choice is academically justifiable, on the basis that clinicians can reasonably be expected to engage in processes of reflective practice, whereby they gain an explicit and articulable understanding of therapeutic processes.

Table 10.1
Questionnaire Respondents' Country of Practice

	Total Frequency	Percent (%)
United Kingdom	121	76.1
United States	23	14.5
Australia	8	5.0
Canada	2	1.3
Uruguay	2	1.3
Italy	1	0.6
Switzerland	1	0.6
Egypt	1	0.6
Total	*159*	*100.0*

While a majority of respondents overall (76.1%) report the UK as their country of practice, the geographical distribution of respondents in the specialist and generalist subgroups differs. Table 10.2 shows the frequency distribution of respondents' country of practice, by organization.

Table 10.2
Questionnaire Respondents' Country of Practice by Organizational Membership

	Country	Total Frequency	Percent (%)
Sex Therapy Specialists			
SSSS	United States	7	70.0
	Canada	2	20.0
	Australia	1	10.0
	Total	10	100.0
AASECT	United States	5	100.0
SSTAR	United States	11	100.0
RELATE	United Kingdom	7	100.0
COSRT	United Kingdom	46	83.6
	Australia	7	12.7
	Uruguay	2	3.6
	Total	55	100.0
Psychotherapy Generalists			
UKCP	United Kingdom	37	92.5
	Italy	1	2.5
	Switzerland	1	2.5
	Egypt	1	2.5
	Total	40	100.0
BACP	United Kingdom	15	100.0
BPS	United Kingdom	10	100.0
BPC	United Kingdom	6	100.0
Total		*159*	100.0

Amongst sex therapy specialist participants (those registered with SSSS, AASECT, SSTAR, RELATE and COSRT), 60% (n=53) report practicing in the United Kingdom, while 26% (n=23) report practicing in the United States, and 9.1% (n=8) report practicing in Australia. Response rates from other regions are low. Sex therapists in the United States may be underrepresented relative to the overall composition of the global sex therapy community. Future empirical research examining sex therapy technique and practice in the United States and other regions

outside of the UK is clearly warranted.

Amongst psychotherapy generalists (those registered with the UKCP, BACP, BPS or BPC), 95.77% (n=68) report practicing in the United Kingdom, with no practitioners reporting as practicing in the United States. Consequently, practitioners outside of the UK are unrepresented in the psychotherapy generalist sample. Future research examining the techniques used by psychotherapy generalists in other regions, including the United States, is warranted.

The main risk of selection bias in the questionnaire likely stems from the fact that sex therapists are not necessarily members of the aforementioned groups, and the list of organizations (both generalist and specialist) from which the research sample is drawn, does not encompass the entire community of psychotherapists who treat sex therapy. As such, there were psychotherapists and sex therapists who treat male sexual dysfunctions who had no chance of being selected for this survey. This risk, however, is lessened in the UK, where psychotherapy licensure is administered at the national, rather than state or provincial, level. The majority of licensed, practicing sex therapists are registered with COSRT and/or one of the generalist organizations targeted in this survey, while a significant proportion of licensed psychotherapists in the UK are registered with the UKCP, BACP, BPS, or BPC.

A significant consideration is whether the sampling frame is reflective of the population under study. The member populations in the organizations that comprise this survey's sampling frame can reasonably be deemed representative of the population of licensed psychological health professionals who treat men's sexual dysfunctions. However, as the designation 'psychotherapist' is not statutorily protected in UK law, it is possible that there may be a number of unlicensed practitioners, who are not affiliated with any of the professional organizations targeted in this survey. Nonetheless, as stated, the majority of licensed UK psychotherapists are affiliated with one or more of the professional organizations sampled, and it can be inferred that the sampling frame is adequately representative of the studied population.

The second threat to representativeness consists in the possibility of response bias, which occurs when certain participants systematically fail to complete the survey. The primary foreseeable concern consists in the use of the Internet for questionnaire administration. As Shaughnessy et al. state, with Internet surveys, "selection bias is present because respondents are a convenience sample of individuals who have Internet access" (2006, p. 161). This study, however, examines

a specific professional population, and it is reasonable to surmise that the vast majority (if not all) of the research subjects have Internet access. As such, as a medium of survey administration, the Internet likely does not introduce significant selection bias. In sum, the risk of sampling bias is considered minimal, and the survey sample can, most likely, be treated as representative, with the geographical limitations noted above.

10.3.2. Interview Limitations

A key problem with the interview method of data collection consists in the risk of a *social interaction effect*. This risk is the most significant concern for the interview component of this research. DiLalla and Dollinger address this problematic effect, emphasizing that "beyond the characteristics of experimenters, the interaction of experimenter and participant can subtly influence research findings and introduce error into our work" (2006, p. 243). Perhaps the most salient interaction effect (and the one most worrisome for this research), they suggest, is the *experimenter-expectancy effect*; in this phenomenon the researcher's biases affect the way the interview is conducted and/or the way the interview data are interpreted. Within the interview, the experimenter-expectancy effect can take the form of leading questions that influence the respondent by the manner in which they are phrased or delivered. Within the data analysis process experimenter bias can also prejudice the way in which the researcher interprets and represents the research findings (Langdridge & Hagger-Johnson, 2009). Researcher bias is addressed in the following section. The other noteworthy limitation of the interview survey consists in the degree to which research data are generalizable. As with any comparable research project, with a limited sample population these research findings might not be applicable throughout the clinical community.

10.4. Integrity of Study Data

The steps taken to ensure the quality and integrity of the data were described in detail in chapter 4. However, before considering the next steps in this research area (section 10.5), and summarizing the contribution that this research project makes to the field (section 10.6 below), it is worthwhile to revisit the issue of data integrity.

In the initial planning phase of this research project, the primary aim envisioned was to test a positive hypothesis. The preliminary research question in the planning phase was, "which psychodynamic techniques are most commonly used

by sex therapists, and how can these techniques be optimally integrated within the integrative biopsychosocial treatment of men's sexual dysfunction?" The positive hypothesis herein was that psychodynamic methods are currently used by sex therapists and the research programme was originally envisioned based on this assumption. Early consultation with the research supervisors for this project clearly established the problem with this orientation. Best practices in scientific research in general, and health research specifically, hold that assessing a positive hypothesis may be conducive to bias and may jeopardize the research methodology of a project (Foster, 2001; Popper, 2014/Orig. 1959). Experts on research methodology assert that confirmatory results, and type I errors (i.e. finding a positive effect where none exists) are increasingly probable within this orientation (Freeman, Tyrer, & Tyrer, 2006; Popper, 2013/Orig. 1983)

To help control against this effect, the primary research question was re-framed to better account for the possibility of a null result, and was rearticulated as described in chapter 1. The revised research question aimed first to determine *whether* psychodynamic techniques and theories are currently used in sex therapy, rather than presupposing that psychodynamic methods are used by sex therapists. In short, the fundamental shift in orientation that this change represents is reflected in the clear acknowledgment that sex therapists might not use psychodynamic techniques in their work with male clients.

Additionally, a number of secondary research aims (as described in chapter 1, and chapter 4) were developed, in order to expand the scope of the research and gain a wider, more contextual and more nuanced set of data on the principles and practices of sex therapy. With respect to the primary research question, these secondary aims sought to confirm whether psychodynamic principles and practices hold a place in the sex therapy field, and—if a positive result was found—to determine how these psychodynamic methods are incorporated within current practices. To this end, data was gathered on a number of measures of clinical practice described in this thesis, including respondents' use of biopsychosocial methods, combinative techniques, goal-setting, interpretations of aetiology, and perspectives on diagnosis.

As outlined in chapter 4, a number of steps were taken to control for researcher bias and protect the integrity of the data gathered in this process. First, the development of the survey was subject to several phases of pilot testing for both the quantitative and qualitative measures used. Additionally, peer-review was used

throughout the development, data collection, analysis and writing stages. Regular consultation with research supervisors was also engaged at every stage in the research process. Another practice that proved valuable, particularly for controlling against researcher bias, was the use of structured reflective practice activities—especially the use of a reflective practice journal (see also section 4.6, above).

There are three other aspects of the research project that contributed to the maintenance of reflective practice and helped to ensure valid data. First, formal and informal peer consultation with fellow students and colleagues was invaluable in helping to ensure close critical scrutiny of the research methods used. During the period of study, the author of this study worked with academic peers in organizing a research seminar series, which afforded the opportunity to share work in progress, and gain feedback. Alongside numerous informal consultations with my fellow students, this formal opportunity to gain feedback from my colleagues proved very useful to my work. Additionally, portions of this research were presented at a number of academic conferences, clinical rounds, and professional seminars throughout the project. Feedback from professional colleagues, and senior researchers and clinicians was an asset in ensuring the quality of the data. Finally, feedback from the research participants themselves was a great resource that contributed to the quality of this work. The questionnaire (appendix A) invited feedback from the research participants on aspects of their clinical practice that might have been overlooked in the study; additionally, feedback was also invited from interview participants on areas not covered in the research interviews. The quality of this research project was enhanced immeasurably by input and contributions from all of these groups.

10.5. Next Steps

The foremost next step in this research area will be to evaluate the primary research focus—the use of psychodynamic methods in sex therapy—through an observational research method. Moving forward, it would be worthwhile to develop a research project in which actual sex therapy sessions are videotaped and coded to assess the use of specific psychodynamic techniques. The research project reported in this thesis serves as a foundation for an observational project of this nature, as key prototypical and distinctive psychodynamic techniques have been identified and measured according to clinicians' self-reporting. In sum, the initial next step in this research area is to further test clinicians' self-reported use of psychodynamic

techniques, through direct analysis of therapy sessions.

Secondarily, this research area will progress through the implementation of outcome measures, which assess the efficacy of psychodynamic techniques relative to other interventions, in the sex therapy field. It has been reported that psychotherapy outcome studies are one of the most important frontiers for research in the sexual health field, making this a high priority for psychodynamic research (Binik & Hall, 2014). Future research will likely include the administration of pre- and post-treatment measures that evaluate a number of measures of sexual and relational functioning and satisfaction. The emphasis placed on the importance of the interpersonal relationship in the sex therapy process, as discussed in chapter 5, underscores the importance of including relationship factors in the assessment of treatment outcomes.

Data from this study, presented throughout this thesis, highlight the applicability of attachment theory, and the relevance of client attachment style for sexual behaviour and sexual problems. The salience of attachment style in these data indicates that an important area for future research is the assessment of the interaction between client attachment style, sexual problems, and treatment, an area that researchers have begun to examine more rigorously in recent years (Stefanou & McCabe, 2012). My goal is to develop future research projects that evaluate whether there is a correlation between particular attachment styles and particular sexual problems. An emergent related question in this area, which may be explored through pre- and post-treatment measures, is whether sex therapy, and specifically psychodynamic techniques, have an effect on client attachment style and, if so, how this effect correlates with other measures of treatment outcome.

The need for treatment outcome measures, and research on the role of attachment in sexual dysfunction and treatment, underscore the importance of a general area for future research: assessment of sex therapy clients' experiences. As stated above, a principal limitation of this study is its focus on clinicians' self-report; the future research initiatives identified in this section will be best served by the inclusion of experimental research and direct evaluation of the client experience.

Data relating to the secondary aims of this study present a number of other areas for future research. Research projects further evaluating sex therapists' use of biopsychosocial practices are warranted. This area of study may assess sex therapists' level of adherence to the biopsychosocial paradigm, and analyse different strategies of biopsychosocial integration used by practitioners, in particular

longitudinal tracking of referral processes. This research area will seek to address a number of questions including:

- What proportion of sex therapy clients are referred for medical consultation/screening?
- What proportion of sex therapy clients are referred for psychotherapeutic treatment by a medical care provider in the first instance (i.e. in cases where the medical provider's assessment has ruled out primarily physiogenic dysfunction and suggested psychosocial or combined aetiology)?

In this area, outcome research is also warranted, to ascertain whether treatment outcomes differ between sex therapists who work in integrated multidisciplinary facilities, those who use the type of interdisciplinary referral network Perelman describes as a 'virtual' multidisciplinary team (2005c), and those who make scant use of referral or integration. A fundamental question for this research area is: how does multidisciplinary integration correlate with treatment outcome? As discussed in chapter 5, early research has shown that combined/integrative biopsychosocial treatments likely have favourable treatment outcomes when compared with mono-modal interventions. However, further research is needed to determine which psychotherapeutic practices are best included in medical-psychotherapy integration models, and how these models can feasibly be implemented across settings.

Another issue that is of high emphasis in my current work, which I consider an area of crucial importance for both psychotherapy and sex therapy researchers, is the use of critically-oriented practice in sex therapy (Berry & Barker, forthcoming 2015). In this respect, the diversity and uniqueness of sex therapy clients is a vital consideration, and encompasses sexual diversity, gender issues, cultural diversity, and diverse and varied sexual practices (Graham & Hall, 2012). While the discussion of critical sex therapy and working with client diversity offered in chapter 7 of this thesis may serve as a point of departure for future research, it is important to note that this is a vast and complex subject area. In considering the principal area of focus of this study—psychodynamically-informed theory and practice—a focus for future work comes to light. Specifically, how might psychodynamic methods be utilized to facilitate work with diverse clients? Can psychodynamic methods help clinicians to acknowledge, respect, and honour client diversity? Successful research in this area may utilize techniques described above. In particular, it may be useful to videotape and code psychotherapy sessions, and combine this with client self-report as to the methods that were found most and least useful in the therapy process.

The next steps and potential areas for future research outlined here do not comprise an exhaustive list. Some of the most important and cogent next steps for further examination have been described. However, the data yielded in this study may generate considerable curiosity, highlighting the limitations of our knowledge of sex therapy practice, and deficits in the current research. Nonetheless, this study helps to edify a number of areas of relevance, and this thesis concludes with a discussion of the unique contribution this research programme makes to the field of scholarship.

10.6. Where this Study Fits: The Contribution of this Research to the Field

This research project contributes to the field by illustrating that the baby has *not* been thrown out with the bath water (Kirman, 1998; Luyten et al., 2006). The data gathered in this study indicate that psychodynamic theory continues to exert a significant influence over sex therapy, and that sex therapists continue to use psychodynamic techniques to a significant degree in their work with male clients. Previous research has indicated that psychodynamic psychotherapy may have some impact on the work of sex therapy practitioners, contributing to the development of the hypotheses tested in this research project (Berry, 2013b; Hartmann, 2009; Shedler, 2010; Waldinger, 2006, 2013; Westen, 1998, 2000). However, the extent of this influence, and the variable influence of different psychodynamic methods, was unknown. The finding that psychodynamic techniques may be comparably prevalent to CBT techniques in sex therapy practice is of particular significance, given the relatively common assumption that the core techniques of sex therapy are behavioural (Annon, 1974, 1975; Bancroft, 1977; Hawton, 1985, 1998; Masters & Johnson, 1966; Masters & Johnson, 1970).

As stated above, research on the contemporary role of psychodynamic practices in sex therapy is scarce, and empirical research on this topic is virtually inexistent. This research project makes a significant contribution, not only by quantitatively assessing clinicians' self-reported use of psychodynamic techniques, but by providing detailed evidence on the specific psychodynamic techniques used. Data from this study confirm that attachment theory, in particular, has been embraced by sex therapy specialists. While research on the use of attachment in couple and sexual counselling is a growing area (Diamond et al., 2011; Stefanou & McCabe, 2012), there is little quantitative research on the interaction between sex therapy, attachment theory, and other psychodynamically-informed methods. In this respect, also, this

research project contributes new knowledge to the research sphere.

This thesis has repeatedly stressed the salience of psychosocial and relational factors within the data. An important implication of the findings is that relational psychodynamic models appear to have more interest, and perhaps more relevance, for sex therapists than the wider literature might suggest. This discovery may help explain the research findings on the link between sex therapy and attachment theory, and the prominent importance of early life factors, including the influence of the client's family of origin, on sexual functioning. Because psychosocial and relational factors are accorded such high priority, the client's attachment style, and the early life experiences that affect the client's relationship patterns, are key areas for sex therapists. In short, this research has determined that the client's early life remains an important element of focus for sex therapists, and is often considered through the lens of psychodynamic theory.

Often, however, psychosexual therapists may not explicitly recognize their perspective as psychodynamic. In this regard, the data in this research project confirm outside work indicating that psychodynamic methods may often be used implicitly, without the acknowledgment of the psychotherapist using them (Shedler, 2010). In the psychosexual therapy field specifically, however, this is a new finding, and lays the groundwork for future research assessing the efficacy of implicit versus explicit use of psychodynamic techniques.

This research project also has fulfilled a number of secondary aims (outlined in chapter 1 and chapter 4), which may enhance the contribution this work makes to the field. To my knowledge, this is the first attempt to analyse the contribution of psychodynamic psychotherapy within the biopsychosocial model of sexual healthcare. As the biopsychosocial model is confirmed as a care standard in the sexual health field, future research evaluating the use and efficacy of psychodynamic methods in this field will likely need to closely consider the role of the biopsychosocial paradigm (Montorsi, Basson, et al., 2010). This thesis has also provided detailed discussions of several specific areas of practice—diagnosis and assessment, case formulation and goal setting, critical sex therapy, and aetiological conceptualization. By evaluating these aspects of clinical practice as comprehensively as possible, this research project has attempted to situate psychodynamic theory and technique in relation to the principal domains of clinical work. The data gathered in this study appear to confirm that psychodynamic practice influences sex therapy across these domains.

This thesis began with the assertion that psychoanalysis (still) matters, and sought to test this claim by assessing if, and how, psychodynamic psychotherapy influences psychotherapists. The data has been largely confirmatory, and useful in clarifying the areas of influence spelled out above. Indeed, psychoanalysis still matters, but not all dimensions of psychodynamic theory/practice are equally influential or important to contemporary sex therapy practitioners. Perhaps most importantly, however, this research project has confirmed that the keystone of psychodynamic practice—the importance accorded to the unconscious, and the necessity of working to gain insight into unconscious factors—is still relevant for sex therapists. Attention to unconscious factors appears to influence all stages of sex therapy practice. Thus, the data suggest that sex therapy shares a fundamental aim with psychodynamic psychotherapy: to foster reflective functioning and insight, and to help bring the unknown elements of the client's sexual problems to light.

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Appendix A - Complete Questionnaire

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Survey on the Psychotherapeutic Methods Used in Treating Men's Sexual Dysfunctions

Question References (in order as shown*):

Cognitive Behavioural Therapy:
Questions 1-10 adapted from Ablon & Jones (1998)
Questions 12-14 adapted from Masters & Johnson (1982, 1975, 1970 1966)
Questions 15-22 adapted from Allen (2006), and Drummond & Kennedy (2006), and Blagys and Hilsenroth (2002)

Psychodynamic Therapy:
Questions 1-16 adapted from Ablon & Jones (1998)
Questions 17-20 adapted from Hobbs (2006) and Blagys and Hilsenroth (2000)

* In the administered version of the survey, the order of the questions on technique (listed here) was randomized.

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Survey on the Psychotherapeutic Methods Used in Treating Men's Sexual Dysfunctions

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MPhil/PhD Researcher
Department of Psychology,
University College London

January 18th, 2011

Survey Purpose:

This questionnaire is part of the research I am conducting for my PhD in Psychology at University College London. It is designed to examine current psychosocial practices in the treatment of men's sexual dysfunctions. This research project is a descriptive study of general practices, and seeks to determine which psychotherapeutic methods are most commonly used in the treatment of men's sexual dysfunctions, and which methods clinicians deem most effective.

In addition to this questionnaire, my research entails verbal interviews with practitioners—it is my hope that you may be interested in participating in an interview as well (hence the option, as you will see, for you to provide your contact information). Whether you choose to participate in a verbal interview or not, the data gathered on this questionnaire will be kept entirely confidential.

The data from this study will be reported in my PhD dissertation. It may also comprise the research base for academic publication in papers, at conferences, etc. In addition, this study may serve as a point of departure for future research. The results of this study will be made available to you, upon completion of the research project.

If you have any questions about this research, you are invited to contact me at +44 (0) 77 4202 7626 or via email at michael.berry.10@ucl.ac.uk. You can also contact my supervisor, Professor Peter Fonagy, at +44 (0) 20 7679 1943, or via email at p.fonagy@ucl.ac.uk.

Thank you for your interest in this research project.

Michael D. Berry

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Statement and Declaration of Informed Consent:

Your participation in this study is completely voluntary. You have the right to stop the questionnaire at any point in time without repercussion.

You will be given the option to enter your contact information at the end of the survey. I will use this information to contact you if you are willing and able to participate in a verbal interview.

This questionnaire is administered by secure means (if you are taking it online, please note that it is hosted and submitted through a secure, encrypted server). If you choose to provide your contact information, please note that this information will be held in strict confidence. All data are held on a password-protected computer with back up, paper copies kept in a locked filing cabinet in my workspace.

☐ **I have read and understood the information provided above.** I consent to participate in the questionnaire, conducted by Michael Berry of the Psychology Department at the University College London.

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Demographic Questions:

This survey examines the role of psychotherapy in the treatment of men's sexual dysfunctions. In your practice, do you see and treat men's sexual dysfunctions?

☐ Yes
☐ No

What is your professional title/designation?

☐ Clinical Psychologist
☐ Counselling Psychologist
☐ Psychotherapist
☐ Psychiatrist
☐ Licensed Clinical Social Worker
☐ Medical Doctor—General Practice/Internist
☐ Medical Doctor—Urologist
☐ Medical Doctor—Cardiologist
☐ Medical Doctor, other (please specify credential) _____
☐ Nurse
☐ Licensed Counselor (please specify credential) _____
☐ Other (please specify) _____

In which country do you practice?

In what capacity are you employed?

☐ Public health services
☐ Corporate employment
☐ Self-employed (private practice)
☐ Other (please specify) _____

How long have you been working in the treatment of men's sexual dysfunctions, not including training?

☐ 1-4 years
☐ 5-9 years
☐ 10-14 years
☐ 15-19 years
☐ 20-24 years
☐ 25-29 years
☐ 30-34 years
☐ 35-39 years
☐ 40+ years

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What is your gender?

☐ Male
☐ Female
☐ Other
☐ Prefer not to say
Have you remained in the gender you were assigned at birth? ☐ Yes ☐ No

---

General Practice Questions

Approximately how many cases, in total, of male sexual dysfunction have you treated in your practice

☐ 1-20
☐ 21-40
☐ 41-60
☐ 61-80
☐ 80+

On average in your practice, approximately how many sessions does successful treatment for male sexual dysfunction take?

☐ 1-2
☐ 3-4
☐ 5-6
☐ 7-8
☐ 11-12
☐ 13-14
☐ 15-16
☐ 17+

*Please note—this survey assumes that therapists will define "successful" treatment outcomes differently. Questions on the standards of "success" you employ in your practice are addressed later in this survey.

During treatment, approximately how many times per month do you see a patient you are treating for sexual dysfunction?

☐ 1
☐ 2
☐ 3
☐ 4
☐ 5+

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In men you have treated, how would you rate the overall treatment outcome for the following sexual dysfunctions, from never successful (1) to always successful (5)?

Erectile Dysfunction	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A*
Premature Ejaculation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A*
Sexual Aversion Disorder	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A*
Hypoactive Sexual Desire Disorder	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A*
Ejaculatory Disorder	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A*

*N/A = Not applicable (i.e. you have not treated this dysfunction in your practice)

In <u>the most recent case</u> you have treated, of each of the following male sexual dysfunctions, how would you rate the overall treatment outcome, from (1) totally unsuccessful to (5) completely successful

Erectile Dysfunction	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A*
Premature Ejaculation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A*
Sexual Aversion Disorder	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A*
Hypoactive Sexual Desire Disorder	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A*
Ejaculatory Disorder	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ N/A*

*N/A = Not applicable (i.e. you have not treated this dysfunction in your practice)

Treatment Paradigm/Philosophy Questions

How would you designate the primary (i.e. preferred) treatment methodology you use in treating male sexual dysfunctions (please note, it is understood that you may use multiple methods in practice, and this is a non-exclusive designation)?

☐ Cognitive Behavioural Therapy
☐ Psychoeducational Therapy
☐ Systemic Therapy
☐ Psychodynamic Therapy
☐ Cognitive Analytic Therapy
☐ Experiential Therapy
☐ Inter-personal Therapy
☐ Integrative Treatment Therapy (please specify treatments) _____
☐ Medical—Pharmacological
☐ Medical—Surgical
☐ Other (please specify) _____

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Which of the following statements best describes your view on the biopsychosocial treatment model?*

☐ Not important
☐ Somewhat important
☐ Important
☐ Very important
☐ Essential

The biopsychosocial treatment model explicitly focuses on dysfunctions as multi-faceted; in this system, both the cause and the symptom-structure of a dysfunction entail some combination of biological, psychological and social factors. Consequently, in this model treatments also acknowledge all three spheres.

On average, in the treatment of men's sexual dysfunctions, to what extent do you use the biopsychosocial treatment model (i.e. taking all three facets into account in diagnosis, and treating all three facets, or referring for treatment of all three facets as needed)?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

With the <u>most recent</u> patient that you treated for male sexual dysfunction, to what extent did you use the biopsychosocial treatment model?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

In your view, in the treatment of men's sexual dysfunctions how important is pharmacotherapy (drug therapy)?

☐ Not important
☐ Somewhat important
☐ Important
☐ Very important
☐ Essential

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In your view, in the treatment of men's sexual dysfunctions, how important is psychotherapy?

☐ Not important
☐ Somewhat important
☐ Important
☐ Very important
☐ Essential

In your practice, in the treatment of men's sexual dysfunctions, how frequently do you collaborate with other health services professionals?

☐ Never
☐ Occasionally
☐ As often as not
☐ Usually
☐ Always

With the most recent patient that you treated for male sexual dysfunction, to what extent did you collaborate other health services professionals in providing patient care/treatment?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

In treating men's sexual dysfunctions, how often do you believe that a combination of psychotherapy and pharmacotherapy is warranted?

☐ Never
☐ Occasionally
☐ As often as not
☐ Usually
☐ Always

With the most recent patient that you treated for male sexual dysfunction, to what extent did you use or encourage a combination of psychotherapy and pharmacotherapy?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

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In treating men's sexual dysfunctions, how often do you use a couples' counseling/psychotherapy approach (i.e. counseling both members of a couple, either separately or together), assuming a patient has a partner?

☐ Never
☐ Occasionally
☐ As often as not
☐ Usually
☐ Always (where possible/applicable)

With the <u>most recent relevant patient</u> (i.e. patient with a partner), to what extent did you use a couples' counseling/psychotherapy approach?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

Cognitive-Behavioural Therapy Questions

The following questions on general practice inquire about the techniques you used in *the most recent case* of male sexual dysfunction you treated.

1) In the most recent case of male sexual dysfunction you treated, to what extent did you discuss specific activities or tasks for the patient to attempt outside of the session?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

2) In the most recent case of male sexual dysfunction you treated, to what extent did clinical discussion focus on cognitive themes (i.e. about ideas or belief systems)?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

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3) In the most recent case of male sexual dysfunction you treated, to what extent did you encourage the patient to try new ways of behaving with others (i.e. sexual partners)?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

4) In the most recent case of male sexual dysfunction you treated, to what extent did you exert control over the interaction (e.g. structuring the session, introducing new topics)?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

5) In the most recent case of male sexual dysfunction you treated, to what extent did you try to ensure that the dialogue had a specific focus?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

6) In the most recent case of male sexual dysfunction you treated, to what extent did you emphasize the patient's current or recent life situation in discussion?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

7) In the most recent case of male sexual dysfunction you treated, to what extent did you give explicit advice and guidance?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

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8) In the most recent case of male sexual dysfunction you treated, to what extent did you behave in a teacher-like (didactic) manner?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

9) In the most recent case of male sexual dysfunction you treated, to what extent did you explain the rationale behind the technique or treatment approach you used?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

10) In the most recent case of male sexual dysfunction you treated, to what extent did you encourage independence of thought or opinion in the patient?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

11) In the most recent relevant case of male sexual dysfunction you treated (i.e. with a patient who has/had a sexual partner) to what extent did you use/prescribe sensate focus exercises*?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

* Sensate focus exercises (as advocated by Masters and Johnson) are a step-wise system of sexual activity in the physician advises the patient to move gradually, over the course of several sexual encounters, through a series of initially non-coital sexual activities with his partner. By design, these activities increase in stimulus intensity and genital focus and, theoretically, culminate (at the end of a number of sessions) in sexual intercourse. Exercises typically include some progressive combination of: clothed non-genital touching, clothed genital touching, naked non-genital touching, naked-genital touching, non-thrusting containment, and thrusting penetration.

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12) In the most recent case of male sexual dysfunction you treated, how often did you use/prescribe intercourse prohibition?*

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

* In intercourse prohibition, the therapist advises a patient not to have sexual intercourse, temporarily, while they work to resolve other issues, or work to realize a particular therapeutic technique (for instance, in the first steps of sensate focus exercises, the patient would be advised not to have full intercourse).

13) In the most recent case of male sexual dysfunction you treated, how often did you use/prescribe directed masturbation exercises*?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

*In directed masturbation exercises, the patient engages in a series of extra-therapy self-stimulation activities, which may include visual and tactile self-examination, genital exploration and touching, use of erotica, and self-monitoring (i.e. monitoring arousal and conditions of arousal).

14) In the most recent case of male sexual dysfunction you treated, did you try to quantify (i.e. precisely and numerically) the patient's sexual function/dysfunction?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

15) If you *did* try to numerically quantify the patient's sexual functioning/dysfunction, can you elaborate on the measurement/instrument you used?

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16) In the most recent case of male sexual dysfunction you treated, did you set (or help the patient set) explicit and measurable treatment goals?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

17) In the most recent case of male sexual dysfunction you treated, to what extent did you use precise and fixed time limits?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

18) In the most recent case of male sexual dysfunction you treated, to what extent did you use systematic desensitization?*

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

*Systematic desensitization is a technique in which the patient is taught specific skills and techniques to combat anxiety (based on the premise that "if a state incompatible with anxiety can be produced then anxiety cannot occur")[Drummond & Kennedy, 2006: 169]. Systematic desensitization often uses gradual/graduated exposure, combined with relaxation techniques.

19) In the most recent case of male sexual dysfunction you treated, to what extent did you use patient questionnaires in assessing/measuring patient condition and/or treatment progress?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

20) If you *did* use questionnaires, can you comment on what type of questionnaires you used (i.e. sexual functioning inventories, self-report, partner report, self observation, partner observation, etc.), and how you used them?

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21) In the most recent case of male sexual dysfunction you treated, to what extent did you examine/explore and attempt to treat patients' automatic thoughts?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

22) In the most recent case of male sexual dysfunction you treated, to what extent did you promote acceptance* over change?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

*tenet of Dialectical Behaviour Therapy, Mindfulness-based Cognitive Therapy

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Psychodynamic Therapy Questions

1) In the most recent case of male sexual dysfunction you treated, how frequently did you discuss/examine the patient's fantasies and/or dreams?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

2) In the most recent case of male sexual dysfunction you treated, did you point out/illustrate a patient's resistance to treatment (i.e. defensive maneuvers, such as denial)?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

3) In the most recent case of male sexual dysfunction you treated, to what extent did you examine/explore the patient's unconscious thoughts/feelings?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

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4) In the most recent case of male sexual dysfunction you treated, to what extent did you work to convey a sense of nonjudgmental acceptance?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

5) In the most recent case of male sexual dysfunction you treated, how often did you establish the patient's achieving new understanding/insight as a therapeutic goal?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

6) In the most recent case of male sexual dysfunction you treated, to what extent did you discuss the therapy relationship (i.e. the relationship between the therapist and the patient) with the patient?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

7) In the most recent case of male sexual dysfunction you treated, did you draw attention to feelings the patient may regard as unacceptable (i.e. anger, envy, etc.)?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

8) In the most recent case of male sexual dysfunction you treated, to what extent did you discuss the patient's self-image?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

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9) In the most recent case of male sexual dysfunction you treated, to what extent did you treat the patient's feelings or perceptions as being linked to situations or behaviour of the past?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

10) In the most recent case of male sexual dysfunction you treated, to what extent did you identify/point out recurrent themes in the patient's experience or conduct?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

11) In the most recent case of male sexual dysfunction you treated, to what extent did you comment on changes in the patient's mood or affect?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

12) In the most recent case of male sexual dysfunction you treated, to what extent did you focus on the patient's feelings of guilt?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

13) In the most recent case of male sexual dysfunction you treated, to what extent did you work to help the patient resolve internal conflicts?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

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14) In the most recent case of male sexual dysfunction you treated, to what extent did you examine the patient's formative (earlier life) experiences as influencing current relationships/sexual functioning?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

15) In the most recent case of male sexual dysfunction you treated, to what extent did you use the patient's self-reported subjective satisfaction as a measure of therapeutic success?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

16) In the most recent case of male sexual dysfunction you treated, to what extent did you examine the patient's personal and sexual history?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

17) In the most recent case of male sexual dysfunction you treated, to what extent did you measure progress and outcome against specific, personalized aims for treatment?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

18) In the most recent case of male sexual dysfunction you treated, to what extent did you work to identify recurring themes and patterns in the patient's thought or behaviour?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

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19) In the most recent case of male sexual dysfunction you treated, to what extent did you discuss the patient's past experiences (especially with a developmental focus)?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

20) In the most recent case of male sexual dysfunction you treated, to what extent did you focus on interpersonal relationships?

☐ Not at all
☐ Somewhat
☐ Moderately
☐ To a significant degree
☐ To the maximum possible degree

Finally, can you rate how well (in terms of accuracy and completeness) the above questions capture the techniques you use in treating men's dysfunctions, on a scale of 1 to 100, with **1 being <u>least</u> accurate** and **100 being <u>most</u> accurate?**

Can you identify any techniques that have been overlooked in this survey?

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Debriefing and Further Study:

This completes the online questionnaire. Thank you very much for participating in this survey. Results will be available on the website for this study, when the research project is complete.

In addition to the questionnaire, the research project involves verbal interviews with sex therapy practitioners. If you are willing/able to participate in an interview, please enter your contact information below. Please note that your contact information will be held in complete confidence.

Name:

Professional Designation:

Email:

Contact phone number:

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Appendix B - Introductory Page For Pilot Test

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Survey on the Psychotherapeutic Methods Used in Treating Men's Sexual Dysfunctions

Pilot Group, please note—a number of the questions in this survey are currently organized according to psychotherapeutic methodology (i.e. all questions pertaining to Cognitive Behavioural Therapy are grouped together, all questions pertaining to Psychodynamic therapy are grouped together). In the administered survey, these questions will be re-ordered to minimize the likelihood of respondent bias, and increase the survey's internal validity.

I am hoping to gain your feedback on a number of points:

-Overall clarity of questions and survey structure
-Redundancy
-Overlooked elements (questions that may be worthwhile to include, which are not currently included)
-Appropriateness of survey length (could you please keep track of approximately how long it takes you to complete the survey, as I'd like to calculate the mean estimated time of completion in pilot testing?)
-Impression of survey and survey validity, on a scale of 1-100

The survey aims to assess which therapeutic techniques are (according to practitioner self-report) most frequently used in treating men's sexual dysfunction, and further, which methods practitioners deem most effective/important.

Question References (in order as shown)*:

Cognitive Behavioural Therapy:

Questions 1-11 adapted from Ablon & Jones (1998)
Questions 12-14 adapted from Masters & Johnson (1982, 1975, 1970 1966)
Questions 15-25 operationalized from Allen (2006), and Drummond & Kennedy (2006), and Blagys and Hilsenroth (2002)

Psychodynamic Therapy:

Questions 1-19 operationalized from Ablon & Jones (1998)
Questions 20-25 operationalized from Hobbs (2006) and Blagys and Hilsenroth (2000)

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*Some questions included in the initial pilot study were omitted from the administered version of the questionnaire, based on pilot testers' feedback.

Appendix C - Pilot Test Questions

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Pilot Group Questions:

***These questions address the survey's content, structure and administration, please feel free to use the space provided below to write any comments and suggestions. Thank you for your help in validating this questionnaire.**

How would you rate the overall clarity of questions?

☐ Unclear
☐ Somewhat unclear
☐ Neither clear not unclear
☐ Clear
☐ 'Crystal' clear

How would you rate the survey structure?

☐ Unclear
☐ Somewhat unclear
☐ Neither clear not unclear
☐ Clear
☐ 'Crystal' clear

How would you rate the survey layout and design?

☐ Unclear
☐ Somewhat unclear
☐ Neither clear not unclear
☐ Clear
☐ 'Crystal' clear

How would you rate the survey's user-friendliness?

☐ Difficult to use
☐ Somewhat difficult to use
☐ Neither easy nor difficult
☐ Fairly easy to use
☐ Easy to use

Please estimate how long it took to complete the survey?

☐ 0-4 minutes
☐ 5-9 minutes
☐ 10-14 minutes
☐ 15-19 minutes
☐ 20-24 minutes
☐ 25-29 minutes
☐ 30-34 minutes
☐ 35 minutes or more

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Do you consider this survey appropriate in length?

Given your knowledge of Cognitive Behavioural Therapy and Psychodynamic Therapy, what is your general impression of the validity of this survey?

Please feel welcome to make any general comments or suggestions in the space provided below.

Appendix D

Table 4.2
Questionnaire Pilot Testers' Assessment of Content Validity (responses to the question: "given your knowledge of Cognitive Behavioural Therapy and Psychodynamic Therapy, what is your general impression of the validity of this survey?")

Pilot Tester	Statement	Perception of content validity of survey
1	The survey appears to address both CBT and psychodynamic therapies as best as possible in this format.	Affirmative
2	Pretty good. Further consideration of issues related to recent 'trauma' (either physical or psychological) may be appropriate as treatment approaches may differ (e.g. sexual assault or dysfunction resulting from an accident) In CBT there is likely to be considerable focus on shame for sexual dysfunction.	Affirmative
3	I just don't frame what I do in either camp, so it doesn't fit my way of working or explaining what I do.	Neutral
4	It appears to capture key areas of focus for each therapeutic approach. It should therefore be valid in assessing the use of these approaches in treating disorders of this kind.	Affirmative
5	I found the lay out of the first few questions a bit difficult. However, once you got into the questions about the actual therapy then it was very easy and clear. As I mentioned above I don't very often treat sexual problems but the questions did seem to cover the main areas in CBT approach.	Affirmative
6	Not clear how psychodynamic and CBT were chosen, but I would say that these questions do catch them well.	Affirmative
7	I am not sure of the basic assumptions you make about the concepts of sexual dysfunction and treatment. As I said early on, the confusion between diagnosis and symptom is widespread in this field, and we must remember our Greek, as diagnosis always includes prognosis if we are to 'know through'.	Neutral
8	*No Response*	N/A
9	It's been a while since I worked in the area but this seems good as a measure of CBT/psychodynamic.	Affirmative

10	As a dyed in the wool behaviorist, it is harder for me to assess whether this is a viable measure of psychodynamic psychotherapy. My impression is that it is, but again I am no expert. The CBT part is an accurate reflection of what is done in practice although there are always going to be some things left out. On the whole, yes I consider this a valid measure.	Affirmative
11	Not an expert in sex therapy, but my impression of the metrics used here is that they have good validity for assessing psychodynamic and cognitive-behaviour therapies.	Affirmative
12	The questions look good as measures of cbt and psychodynamic, though you may wish to determine the minimum size of valid question set needed for the results you want, so that you can shorten the question form.	Affirmative

Appendix E

Recruitment Email Template

[email title] Psychotherapy for Sexual Problems: What is the Point? (Survey of [Professional Society Name] Members)

[email text]
If a pill can resolve one's sexual problems, why bother with the longer and more costly process of psychotherapy? The recent pharmacological turn in the treatment of sexual problems puts the future of psychotherapy in question.
Leading scholars contend that if psychotherapy is to defend itself against the challenges pharmacotherapy presents, rigorous, empirical research is essential. This research aims to make an important contribution in this area.

This UCL research project--conducted by PhD candidate Michael Berry, and supervised by Professor Peter Fonagy--aims to establish psychotherapy's usefulness in treating male sexual problems. It is also designed to help determine which therapeutic techniques clinicians find most effective. To achieve results that count, all members of UKCP who have experience in the treatment of men's sexual issues are invited to participate in this survey. The survey takes at most 20-25 minutes and can be completed in multiple sessions. If you would like to participate in the survey, please use the following link and password:

http://www.michaeldavidberry.co.uk/survey.php (depending on your web browser, it may be necessary to cut-and-paste this link)

Password (for [Professional Society Name] members): **[password]** (please note--it is case sensitive)

More information about this project can be found at www.michaeldavidberry.co.uk. Alternatively, please feel free to contact Michael directly with any questions/comments you may have (email: michael.berry.10@ucl.ac.uk, phone: 078 4202 7626).

Thank you, and all the very best,

[email signature]
Michael D. Berry
PhD Candidate
Department of Psychology
University College London
+44 (0)78 4202 7626
www.michaeldavidberry.co.uk

Appendix F - Qualitative Interview Coding Scheme/chart (inter-rater test)

Qualitative Research Interview Coding Scheme/Chart (Inter-rater Test)
Coder:

| | Interviewees discussing themes | | |

Qualitative Research Interview Coding Scheme/Chart (Inter-rater Test) Coder:																																				
	Interviewees discussing themes																																			
	(coders--please mark "I" for implicit mention, "x" for explicit mention, or "XI" for both)																																			
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Couple relationship must be stable/robust enough for sex therapy (i.e. potential for cooperation and communication)																																				
Interviewee emphasizes importance of seeing both members of a couple during assessment																																				
THEMATIC AREA: DIAGNOSTIC PRACTICES																																				
Interviewee expresses a critical view of (standardized) diagnostic model																																				
Diagnostic categories may be labelling/ stigmatizing for the client																																				
Paperwork protocols dependent on work setting/context																																				
Major financial interests (esp. drug companies & insurance companies) influence diagnostic systems or treatment practices																																				
Sexual dysfunction/problem viewed as symptom of other psychological factors (i.e. other psychopathologies)																																				
Need (with some clients) to treat other psychopathologies before treating sexual problem																																				
Treating sexual issue in life context (i.e. expanding focus beyond sexual issue)																																				
Importance of considering social context																																				
THEMATIC AREA: ASSESSMENT PRACTICES																																				

Qualitative Research Interview Coding Scheme/Chart (Inter-rater Test) Coder:																																				
	Interviewees discussing themes																																			
	(coders--please mark "I" for implicit mention, "x" for explicit mention, or "XI" for both)																																			
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Clinician conducts several sessions of assessment																																				
Emphasizes importance of taking a thorough sexual history																																				
Clinician makes little use of questionnaires in sex or couple therapy																																				
Use of open-ended & broad questions to client in assessment																																				
Use of predisposing-precipitating-perpetuating factors model																																				
Clinician views assessment as ongoing throughout treatment process																																				
THEMATIC AREA: GOAL SETTING																																				
Clinician views goal setting as a client-led process																																				
Client seen as the expert on the sexual problem																																				
Interviewee expresses critical view of performance-based sexual model																																				
Interviewee sees performance demand as a causal factor in sexual dysfunction																																				
Goal-setting viewed as a collaborative process/negotiation between client and therapist																																				
Interviewee emphasizes importance of realistic therapy goals (therapist role in ensuring)																																				
Use of shifting formulation																																				

Qualitative Research Interview Coding Scheme/Chart (Inter-rater Test) Coder:																																					
	Interviewees discussing themes																																				
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THEMATIC AREA: CRITICAL SEX THERAPY & DIVERSITY																																				
Interviewee sees knowledge/understanding of diversity as an important skill																																				
Interviewee emphasizes possible need to affirm identities outside the norm																																				
Use of normalizing																																				
Interviewee uses social constructionism to conceptualize client cases																																				
THEMATIC AREA: ETIOLOGICAL FACTORS																																				
Interviewee emphasizes that etiology is multi-factorial																																				
Outside life factors (professional, personal, etc.) contribute to sexual problem																																				
Clinician emphasizes client's early life (as affecting current relationships and sexual functioning)																																				
Clinician focuses on client's family of origin in assessment and treatment																																				
Interviewee emphasizes religious background's potential influence on sex/ sexual functioning																																				
Clinician emphasizes cultural factors' influence on sex/sexual functioning																																				
THEMATIC AREA: PSYCHODYNAMIC THEORY/TECHNIQUE																																				
Clinician focuses on unconscious factors in treatment practice																																				

Qualitative Research Interview Coding Scheme/Chart (Inter-rater Test) Coder:																																				
	Interviewees discussing themes																																			
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Interviewee sees unconscious patterns of thought/affect/behaviour as affecting sexual problem																																				
Clinician views increased insight (for the client) as an overarching therapeutic aim																																				
Interviewee emphasizes that it is important for the client to understanding psychosocial causal factors/etiology																																				
Critical internal voice (esp. parental) seen as a common contributing factor in sexual problems																																				
THEMATIC AREA: INTERVENTION TECHNIQUES																																				
Interviewee uses or recommends intercourse prohibition																																				
Interviewee uses or recommends sensate focus																																				
Clinician believes important part of therapy progress occurs outside of the session																																				
Uses CBT techniques																																				
Importance of therapeutic alliance																																				

Appendix G - Qualitative Interview Coding Scheme/chart

| Qualitative Research Interview Coding Scheme/Chart | | |

Qualitative Research Interview Coding Scheme/Chart																																						
Coder:																																							
	Interviewees discussing themes																																					
	(coders--please mark "I" for implicit mention, "x" for explicit mention, or "XI" for both)																																					
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Interviewee stresses the importance of referral network (and need for diverse, well qualified professionals within)																																						
Interviewee emphasizes limitations of pharmacotherapy																																						
Clinician emphasizes the value of combination therapy model																																						
Essential to integrate drug therapy with other therapy (i.e. couple/sexual therapy or psychotherapy)																																						
Male has control over timing of sex, due to pharmacological interventions																																						
Drug therapies may cause psychological/relational problems																																						
Risk of psychological dependence on drug therapy																																						
Patient/client demand for a medical/ pharmacological treatment																																						
Patients/clients have unrealistic expectations about drug therapies																																						
High dropout rate for drug therapies (i.e. as monotherapy)																																						
Increased number of older clients observed due to pharmacological/ medical advancements																																						
Introduction of drug treatments drew attention to sexual health issues and/or increased number of men treated																																						
Involving partner in pharmacotherapy should be a priority for clinician																																						

Qualitative Research Interview Coding Scheme/Chart																																						
Coder:																																							
	Interviewees discussing themes																																					
	(coders--please mark "I" for implicit mention, "x" for explicit mention, or "XI" for both)																																					
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Clinician uses psychotherapy integration (i.e. integration of different schools/models in ST practice)																																						
Movement towards methodological integration (i.e. of psychotherapy models used), through professional development																																						
Technique/method chosen in vivo, based on current assessment of client needs																																						
Integrating psychodynamic and CBT seen as beneficial																																						
Clinician interweaves psychodynamic and CBT (i.e. non sequential)																																						
Clinician uses psychodynamic techniques to overcome 'blocks' where CBT proves inadequate																																						
Sex therapy in UK seen as more integrative than USA																																						
THEMATIC AREA: COUPLE ISSUES IN SEX THERAPY PRACTICE																																						
Clinician conceptualizes the problem in a social/interrelational way (esp. focusing on couple relationship)																																						
Emphasizes advantages of framing the problem as a couple issue																																						
Clinician seeks to identify the nominated 'carrier' of the problem within the couple																																						

Qualitative Research Interview Coding Scheme/Chart																																						
Coder:																																							
	Interviewees discussing themes																																					
	(coders--please mark "I" for implicit mention, "x" for explicit mention, or "XI" for both)																																					
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Blame (between couple members) seen as a key factor in sexual problems & treatment																																						
Non-sexual relational problems may present as (or intensify) sexual problems																																						
Communication (esp. between partners) seen as a mediating variable in sexual functioning/satisfaction; improved communication sought																																						
Difference in levels of desire (between couple members) seen as common concern																																						
Interviewee emphasizes the value of accepting asynchronous sexual experience (different experience for both partners)																																						
Interviewee indicates 'honeymoon' phase of high desire, evolving into less sexual phase, as typical relationship progression																																						
Clinician uses a systemic psychotherapy/sex therapy orientation																																						
Clinician uses a couple-based treatment approach (i.e. actively involving both couple members)																																						
Couple relationship must be stable/ robust enough for sex therapy (i.e. potential for cooperation and communication)																																						

Qualitative Research Interview Coding Scheme/Chart																																					
Coder:																																						
	Interviewees discussing themes																																				
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Clinician views behavioural interventions as more effective with client in a stable relationship (as opposed to single client, or client in an unstable relationship)																																				
Interviewee frames couple/ relationship counselling as distinct from sex therapy																																				
Relationship therapy may be required before sex therapy																																				
Working with couple together has unique challenges (as opposed to working with individual)																																				
Interviewee emphasizes that couple counselling overlaps with sex therapy																																				
Interviewee emphasizes importance of seeing both members of a couple during assessment																																				
Clinician sees couple members together and separately during assessment																																				
Couple members may have secrets in relation to one another																																				
It may be possible for couple members to be more honest during individual meeting with therapist																																				
Clinician works to identify divergent values between couple members, or conflicting beliefs about sex																																				
Interviewee states that the individual within couple should take responsibility for personal sexuality																																				

Qualitative Research Interview Coding Scheme/Chart																																						
Coder:																																							
	Interviewees discussing themes																																					
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Interviewee stresses importance of relational intimacy for sexual functioning																																						
Reconnecting the couple, or building intimacy, stated as explicit overarching goal																																						
Difference/tension between intimacy and eroticism																																						
Fundamental challenge/aim: integrating intimacy and eroticism into the relationship																																						
Feelings of ambivalence (about sex) are often present in couples																																						
Something initially attractive about partner becomes frustrating in couple relationship																																						
Interviewee emphasizes the damaging effects of ongoing rejection by one partner																																						
THEMATIC AREA: DIAGNOSTIC PRACTICES																																						
Interviewee expresses a critical view of (standardized) diagnostic model																																						
Diagnostic categories may be labelling/stigmatizing for the client																																						
Diagnostic categories seen as describing symptom clusters																																						
Formal diagnostic categories limit treatment innovation																																						

Qualitative Research Interview Coding Scheme/Chart																																						
Coder:																																							
	Interviewees discussing themes																																					
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Interviewee emphasizes that diagnostic categories are used as communication tools (i.e. when referring to medical professionals, or to help client conceptualize a sexual issue)																																						
Paperwork protocols dependent on work setting/context																																						
Use of diagnostic categories dependent on workplace protocols																																						
Major financial interests (esp. drug companies & insurance companies) influence diagnostic systems or treatment practices																																						
Sexual dysfunction/problem viewed as symptom of other psychological factors (i.e. other psychopathologies)																																						
Need (with some clients) to treat other psychopathologies before treating sexual problem																																						
Use of a surrogate partner (esp. to help with skills learning)																																						
Use of mindfulness																																						
Importance of (the client) being mentally/emotionally present during sexual encounter/activity																																						
Treating sexual issue in life context (i.e. expanding focus beyond sexual issue)																																						
Importance of considering social context																																						

Qualitative Research Interview Coding Scheme/Chart																																					
Coder:																																						
	Interviewees discussing themes																																				
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Clinician evaluates both negative and positive influences of social context																																				
Client's intersectional identity (i.e. interesection of different identity factors like gender/race/class/relig.) is seen as important to assessment and clinical work																																				
Interviewee sees gender socialization as an influential factor in sexual functioning																																				
Clinician considers client's social class as influencing sexual problem and/or treatment																																				
Clinician considers client's race/ ethnicity as influencing sexual problem and/or treatment																																				
Interviewee believes the cultural message that male arousal is autonomous/spontaneous affects sexuality																																				
THEMATIC AREA: ASSESSMENT PRACTICES																																				
Clinician conducts several sessions of assessment																																				
Emphasizes importance of taking a thorough sexual history																																				
Interviewee makes variable use of questionnaires																																				
Filling out questionnaire may serve a psychoeducational function for the client																																				

Qualitative Research Interview Coding Scheme/Chart																																					
Coder:																																						
	Interviewees discussing themes																																				
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Clinician makes little use of questionnaires in sex or couple therapy																																				
Use of open-ended & broad questions to client in assessment																																				
Use of predisposing-precipitating-perpetuating factors model																																				
Psychodynamic application of predisposing-precipitating-perpetuating factors model																																				
Clinician views assessment as ongoing throughout treatment process																																				
Attending to unconscious or other psychodynamic factors in assessment																																				
Attending to implicit factors in assessment																																				
Importance of informal assessment (inclusive of unconscious factors)																																				
THEMATIC AREA: GOAL SETTING																																				
Clinician views goal setting as a client-led process																																				
Client seen as the expert on the sexual problem																																				
Success is defined by the client (subjectively)																																				
Interviewee expresses critical view of performance-based sexual model																																				
Interviewee sees performance demand as a causal factor in sexual dysfunction																																				

Qualitative Research Interview Coding Scheme/Chart																																						
Coder:																																							
	Interviewees discussing themes																																					
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Common tendency for people to be orgasm-focused (contributing factor in sexual problems)																																				
Interviewee stresses importance of viewing sex as more than just intercourse/penetration																																				
Interviewee differentiates between arousal and desire																																				
Interviewee places emphasis on pleasure (de-emphasis on performance)																																				
Desire/pleasure/satisfaction emphasized over arousal/orgasm/ performance																																				
Goal-setting viewed as a collaborative process/negotiation between client and therapist																																				
Interviewee emphasizes importance of realistic therapy goals (therapist role in ensuring)																																				
It is common for clients to begin with unrealistic goals																																				
Interviewee emphasizes focus on acceptance (especially as prior to focusing on change)																																				
Goal-setting combines subjective goals with fundamental/universal health principles																																				
Overarching aim: helping the client to formulate and work towards a vision of sexual health																																				
Need for a clearly defined/definable problem to work on in ST																																				

Qualitative Research Interview Coding Scheme/Chart																																							
Coder:																																								
	Interviewees discussing themes																																						
	(coders--please mark "I" for implicit mention, "x" for explicit mention, or "XI" for both)																																						
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Clinician stresses setting specific goals/areas for work																																							
Clinician holds beneficent values/ goals in relation to client & outcome																																							
Clinician attempts to involve both partners in client-led goal-setting process																																							
Usefulness of subjective, client/ couple-specific goals (rather than number of orgasms, etc.)																																							
Partners may have different goals																																							
Problem understood according to client's subjective frame of reference																																							
Use of shifting formulation																																							
Clinician tracks progress of the work																																							
Goals often change/evolve through therapy process																																							
Need for effective progress tracking tool/system																																							
Limitations of quantifying progress																																							
Use of subjective estimate (i.e. "scale of 1-10") rating scales																																							
Need to focus on both positive and negative aspects of therapy progress																																							
Overarching aim: for sex to play a positive role in relationship																																							
Interviewee emphasizes relational intimacy (i.e. between client/ patient and partner) as an overriding treatment objective																																							

Qualitative Research Interview Coding Scheme/Chart																																					
Coder:																																						
	Interviewees discussing themes																																				
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Interviewee sees monogamy as opposed to biology																																				
THEMATIC AREA: CRITICAL SEX THERAPY & DIVERSITY																																				
Interviewee sees knowledge/ understanding of diversity as an important skill																																				
Therapy field seen as ill-equipped to deal with diverse (i.e. LGBT) clients																																				
Interviewee emphasizes that a heteronormative model of sexual behaviour may be common in mainstream sex therapy and/or sexual medicine																																				
Need for more/better training (for sex therapists) in sexual diversity																																				
Interviewee emphasizes possible need to affirm identities outside the norm																																				
Influence of internalized homophobia on client emphasized as important to treatment																																				
Interviewee emphasizes reflective stance (therapist's use of)																																				
Permission-giving as a clinical technique																																				
Use of a non-pathologizing or sexual health model																																				
Use of a dimensional (rather than categorical) model of sexual health/ problems																																				
Emphasis on personal authenticity																																				

Qualitative Research Interview Coding Scheme/Chart																																					
Coder:																																						
	Interviewees discussing themes																																				
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Clinician lets the client lead the therapy process																																				
Use of normalizing																																				
Interviewee uses social constructionism to conceptualize client cases																																				
Interviewee emphasizes fluidity/ variability (and attention to fluidity) of client's identity and sexuality																																				
Narrow definition of "sex" seen as prevalent in society (and as internalized by client)																																				
Heteronormative model of sex seen as prevalent in society (affecting clients)																																				
"Sexual imperative" (assumption that everyone wants sex) seen as prevalent in society																																				
THEMATIC AREA: ETIOLOGICAL FACTORS																																				
Interviewee emphasizes that etiology is multi-factorial																																				
Outside life factors (professional, personal, etc.) contribute to sexual problem																																				
Causal factors seen as overlapping																																				
Clinician emphasizes client's early life (as affecting current relationships and sexual functioning)																																				
Clinician focuses on client's family of origin in assessment and treatment																																				
Clinician uses a developmental focus																																				

Qualitative Research Interview Coding Scheme/Chart																																					
Coder:																																						
	Interviewees discussing themes																																				
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Therapy focuses on influence of early life parental relationship over current sexuality																																				
Therapy focuses on client's attachment relationships/attachment style																																				
Focus on client's relationship schemas, models or scripts																																				
Interviewee emphasizes the significance of past trauma (and its possible influence on current sexual problem)																																				
Interviewee emphasizes religious background's potential influence on sex/sexual functioning																																				
Emphasis on spiritual aspect of sexuality																																				
Interviewee emphasizes possible benefits of involving a religious/ spiritual leader in therapy																																				
Interviewee sees depression as causal/ contributing/underlying factor																																				
Lack of privacy as a contributor to sexual problems																																				
Knowledge/skills (i.e. psychosexual skills) deficits as contributing factors in sexual problems																																				
Interviewee sees anxiety as causal/ contributing factor																																				
Interviewee sees guilt as an etiological/influential factor in sexual problems																																				

Qualitative Research Interview Coding Scheme/Chart																																				
Coder:																																				
	Interviewees discussing themes																																			
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Interviewee sees shame as an etiological/influential factor in sexual problems																																				
Interviewee believes that, for clients, discomfort (i.e. shame or sense of stigma) discussing sex is common and affects treatment																																				
Interviewee stresses the benefit of client disclosure (to prospective partner)																																				
Disclosure of sexual problem (to therapist) may occur later in therapy																																				
Importance of the therapist initiating discussion of sexual aspects																																				
Importance of therapist being comfortable/competent to discuss sex/ sexuality																																				
Clinician emphasizes cultural factors' influence on sex/sexual functioning																																				
Clinician considers the influence of sexually restrictive cultural factors																																				
Sex-negative messages seen as prevalent in Western culture																																				
Sexual difference/non-conformity equated with pathology in Western culture																																				
Clinician uses, or emphasizes use of, psychoeducation																																				
Sexual media (esp. pornography) contributing to unrealistic expectations, fostering sexual problems																																				

Qualitative Research Interview Coding Scheme/Chart																																					
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	Interviewees discussing themes																																				
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Prominence of sex/sexuality in technology and media, influences client																																				
Negative influence of technology (i.e. as distraction, as impeding embodiment, or interpersonal communication)																																				
Positive/mixed influence of technology--new information technologies (esp. internet) may contribute to a more informed client population																																				
Interviewee emphasizes importance of mentalizing capacity (esp. reflective functioning) in client																																				
Clinician sees therapy relationship as fostering mentalization/reflective functioning or mirroring outside relationships																																				
Maladaptive thoughts/beliefs seen as causal factor																																				
Clinician works to identify an unconscious function/meaning of the client's symptom																																				
Therapeutic work explores meanings the client attaches to sex/sexuality																																				
Interviewee identifies client's fear/ avoidance of intimacy or sexual contact as a causal factor in the sexual problem																																				

Qualitative Research Interview Coding Scheme/Chart																																						
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Interviewee states that, for psychoanalytic practitioners specifically, discomfort discussing sex is common																																				
Repression seen as a contributing factor in sexual problems																																				
Interviewee sees avoidant defense as affecting therapy																																				
Resistance--clients often resist treatment/change process																																				
Couple members may collude in resisting change																																				
Clinician may collude with client in resisting difficult work (impedes progress)																																				
THEMATIC AREA: PSYCHODYNAMIC THEORY/ TECHNIQUE																																				
Interviewee states dislike of psychoanalysis, or skepticism about the efficacy of psychoanalysis																																				
Interviewee conflates Freudian Psychoanalysis and Psychodynamic Psychotherapy																																				
Clinician focuses on unconscious factors in treatment practice																																				
Interviewee sees unconscious patterns of thought/affect/behaviour as affecting sexual problem																																				
Therapist works with transference/ countertransference																																				

Qualitative Research Interview Coding Scheme/Chart																																						
Coder:																																							
	Interviewees discussing themes																																					
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Clinician makes implicit use of psychodynamic techniques																																						
Psychodynamic techniques used on an ad hoc basis																																						
Clinician identifies client as narcissistic																																						
Reference to infantile sexuality																																						
Clinician views increased insight (for the client) as an overarching therapeutic aim																																						
Clinician emphasizes new/different perspective (for the client) as a therapeutic aim																																						
Clinician seeks to understand individual's erotic schemas (i.e. "arousal template"/"core erotic themes")																																						
Interviewee emphasizes that it is important for the client to understanding psychosocial causal factors/etiology																																						
Critical internal voice (esp. parental) seen as a common contributing factor in sexual problems																																						
Emphasis on the influence of projection (blaming/projecting) or projective identification onto partner																																						
Emphasis on the influence of projection onto therapist																																						
Clinician uses relational model of psychoanalytic/psychodynamic practice																																						

Qualitative Research Interview Coding Scheme/Chart																																					
Coder:																																						
	Interviewees discussing themes																																				
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Psychodynamic techniques link past to present																																				
Therapist feeling counter-transference feelings towards older clients																																				
Interviewee believes psychodynamic intervention provides more enduring change																																				
Clinician uses interpretations (psychodynamic)																																				
Clinician is tentative in use of interpretations																																				
Psychoanalysis and sexology seen as disconnected																																				
Clinician works with patient's/client's fantasy as clinical material/content																																				
Clinician works with patient's/client's dreams as clinical content																																				
CBT and psychodynamic techniques seen as naturally overlapping																																				
Sensate focus exercises may trigger developmental/attachment issues																																				
Therapist challenging client defenses too much/soon risks reinforcing them																																				
Importance of (both couple and individual) defense mechanisms																																				
Displacement																																				
Intellectualization																																				
Therapist examines/considers client's inner conflicts about sex (i.e. values, behaviours, beliefs, and meanings)																																				

Qualitative Research Interview Coding Scheme/Chart																																					
Coder:																																						
	Interviewees discussing themes																																				
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Somatization seen as important in sexual problems																																				
THEMATIC AREA: INTERVENTION TECHNIQUES																																				
Interviewee uses or recommends intercourse prohibition																																				
Interviewee uses or recommends sensate focus																																				
Clinician believes important part of therapy progress occurs outside of the session																																				
Interviewee uses or recommends use of homework																																				
Interviewee uses or recommends use of cognitive restructuring or reframing																																				
Uses CBT techniques																																				
Focused, time-limited sex therapy seen as ideal																																				
Importance of therapeutic alliance																																				
Importance of therapeutic alliance (and therapist accessibility) in psychodynamic practice																																				
Containment (i.e. therapy process/ therapist as container)																																				
Matching client's emotional tone/state or language																																				
Replacing negative thoughts with positive thoughts																																				
Clinician works in the "here-and-now"																																				

Qualitative Research Interview Coding Scheme/Chart																																						
Coder:																																							
	Interviewees discussing themes																																					
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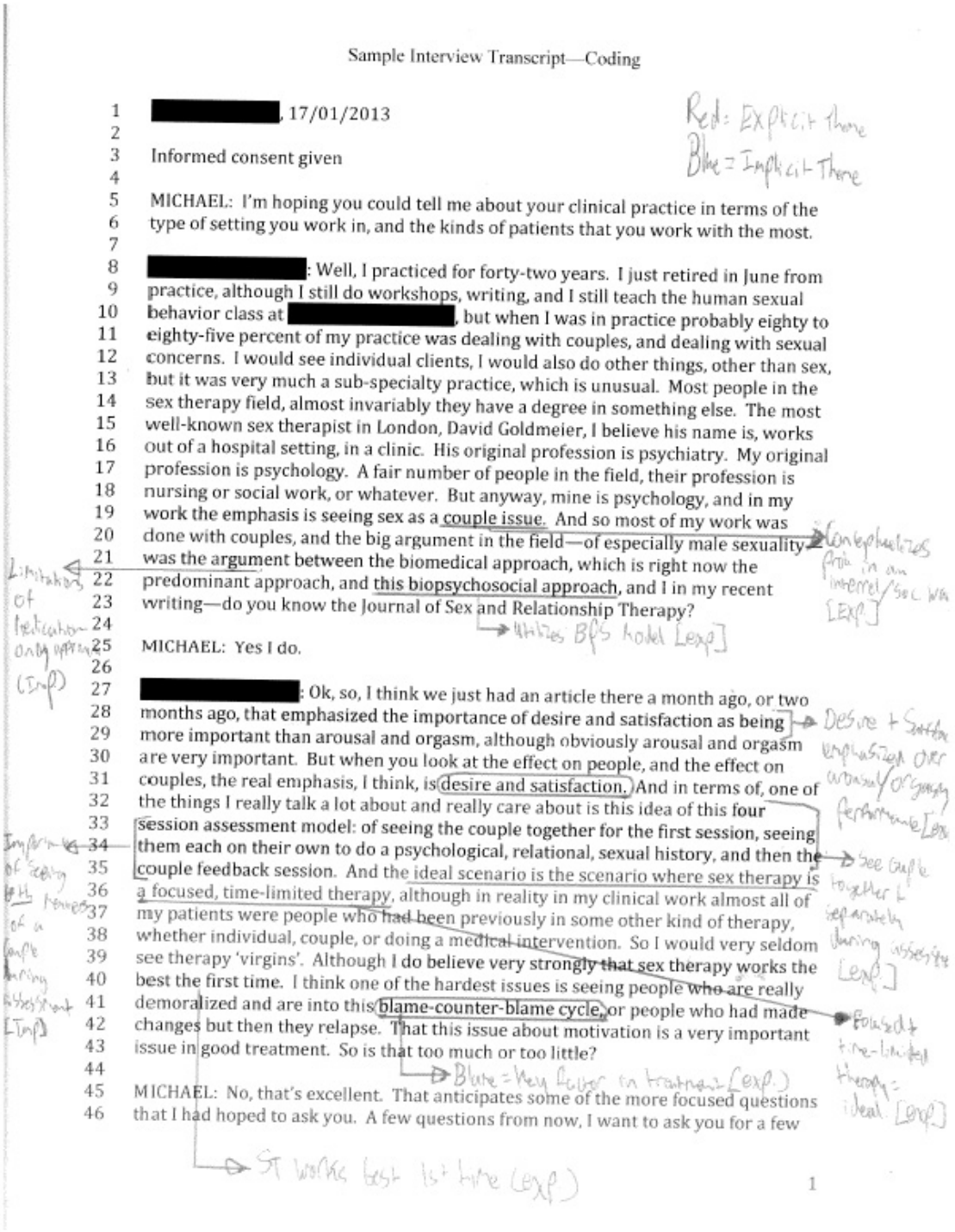
Clinician has an obligation to acknowledge errors/failures																																				
Relapse prevention program/ strategy seen as essential part of comprehensive treatment																																				
Explaining treatment rationale to client																																				
Client self-care emphasized as priority																																				
Interviewee stresses the benefit of early psychotherapy intervention																																				
Discussing what works (in addition to discussing problems)																																				
Importance of identifying 'negatives' (i.e. detrimental aspects) OF WHAT???																																				
Client/patient motivation as predictor of outcome																																				
Need for client to understand clarify values and morals relating to sex																																				
Assess client's (behavioural and affective) capacity for self-regulation																																				
Interviewee emphasizes that sex is/can be frightening																																				

Appendix H



Sample Interview Transcript—Coding

[redacted], 17/01/2013

Informed consent given

MICHAEL: I'm hoping you could tell me about your clinical practice in terms of the type of setting you work in, and the kinds of patients that you work with the most.

[redacted]: Well, I practiced for forty-two years. I just retired in June from practice, although I still do workshops, writing, and I still teach the human sexual behavior class at [redacted], but when I was in practice probably eighty to eighty-five percent of my practice was dealing with couples, and dealing with sexual concerns. I would see individual clients, I would also do other things, other than sex, but it was very much a sub-specialty practice, which is unusual. Most people in the sex therapy field, almost invariably they have a degree in something else. The most well-known sex therapist in London, David Goldmeier, I believe his name is, works out of a hospital setting, in a clinic. His original profession is psychiatry. My original profession is psychology. A fair number of people in the field, their profession is nursing or social work, or whatever. But anyway, mine is psychology, and in my work the emphasis is seeing sex as a couple issue. And so most of my work was done with couples, and the big argument in the field—of especially male sexuality was the argument between the biomedical approach, which is right now the predominant approach, and this biopsychosocial approach, and I in my recent writing—do you know the Journal of Sex and Relationship Therapy?

MICHAEL: Yes I do.

[redacted]: Ok, so, I think we just had an article there a month ago, or two months ago, that emphasized the importance of desire and satisfaction as being more important than arousal and orgasm, although obviously arousal and orgasm are very important. But when you look at the effect on people, and the effect on couples, the real emphasis, I think, is desire and satisfaction. And in terms of, one of the things I really talk a lot about and really care about is this idea of this four session assessment model: of seeing the couple together for the first session, seeing them each on their own to do a psychological, relational, sexual history, and then the couple feedback session. And the ideal scenario is the scenario where sex therapy is a focused, time-limited therapy, although in reality in my clinical work almost all of my patients were people who had been previously in some other kind of therapy, whether individual, couple, or doing a medical intervention. So I would very seldom see therapy 'virgins'. Although I do believe very strongly that sex therapy works the best the first time. I think one of the hardest issues is seeing people who are really demoralized and are into this blame-counter-blame cycle, or people who had made changes but then they relapse. That this issue about motivation is a very important issue in good treatment. So is that too much or too little?

MICHAEL: No, that's excellent. That anticipates some of the more focused questions that I had hoped to ask you. A few questions from now, I want to ask you for a few

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Sample Interview Transcript—Coding

more of your views on biopsychosocial practice, or as you called it in one of your articles: psychobiosocial practice.

[redacted]: Well you know, the person who developed 'Good Enough' couple sex was a much better researcher than myself, and it's Michael Metz, he also was a psychologist—practiced at a medical school in Minnesota. [redacted] I'm now calling it psychobiosocial. And the reason that I emphasize—let's start back. If you think about biomedical versus biopsychosocial, in medicine now, your degree is not in medicine it's in psychology, right?

MICHAEL: That's right.

[redacted]: So, what the psychologists are emphasizing, even the ones that are the most medically oriented, the most biologically oriented, is this more comprehensive approach. And I think what's actually happening, not just in erection problems, but I'm just reviewing a book now on premature ejaculation written by people—I think three physicians, one from Italy, one from Netherlands, and one from Australia—and they're defining premature ejaculation as primarily a biological-genetic problem, with a specific medical intervention, and that the only psychological issues are the sequelae of the problem. And I think that's totally wrong. I think that this more integrative approach, and especially that looks at the couple dynamics, and the interaction between attitudes, behaviors and emotions is so important. Now, the reason I think desire is a major issue is: when you look at the studies—not biological studies, but couple studies. And one of the best people who writes that is a fellow named Stanley Althof, who's now in Florida. And he is always working on these medical grants. But one of the things that Althof makes a really interesting point—I just read this last night—is that when it comes to erection problems, male erection problems, the woman blames herself. When it comes to premature ejaculation problems the woman blames the man. In both cases, though, I think the notion of the man taking responsibility, or the woman taking responsibility, it's this one-two combination: you take personal responsibility for yourself but then to change the problem really takes the two of you working together. The other thing that I really emphasize much more than anybody else that I know, is that I emphasize that you have to have a relapse prevention program as part of a comprehensive treatment. Because if you don't have a relapse prevention program, it is so easy for people to fall back into bad sexual habits. And they then get into this blaming demoralization. The best example of that is the medication for premature ejaculation: when the man drops the medication, he will often get a rebound effect where his early ejaculation will be worse, and the man and the woman will then be worse critics and really fighting and attacking each other, which is bad for the whole system. One last concept that I want to mention, and that is: I think that sex is incredibly paradoxical in people's lives personally, but also in their relationship lives. And that when it functions well, it plays this positive, integral, but not major role. The way I think about it: the major function of sexuality is to allow you to feel desired and desirable, and to energize your relationship bond. The

paradox is that when sex is dysfunctional, especially when the couple are fighting about it, it has an incredibly negative impact, and it really does destabilize both individuals and their relationship. So, what else do you want me to say?

MICHAEL: That makes a lot of sense, and actually, anectodally I should mention that earlier today I talked to Dr. Michal Plaut, and he mentioned your name with regard to relapse prevention, as a matter of fact. So that's maybe of interest. I was hoping to pick your brain a little bit further about the idea of the biopsychosocial model. A quote from your work that is in the literature review for my thesis talks about "treatment of male sexual dysfunction is perhaps the most extreme example of the biomedical model. Although lip service is given to the comprehensive approach, the reality is that most physicians use medication as the first line of therapy for both ED and premature ejaculation". And I wanted to get your thoughts in terms of: what do you think individual practitioners should do to ensure psychobiosocial practice? For both psychotherapists and medical doctors, although of course I'm more interested in psychotherapists.

[redacted]: I do think that the psychotherapists, whether psychologists or some other profession, but even if it's a medical doctor—whether it's an internist or psychiatrist—that he should have, he or she should have a working relationship with a couple therapist, a working relationship, especially for female pain problems, with a physical therapist, should have a working relationship with an endocrinologist or a psychiatrist or whatever, where each person really does function as a team [member]. You know, the best example of all the examples is not a male example. The best example of all the examples is the work of the Canadians in female sexual pain. They have a gynecologist with a subspecialty in female sexual pain. They have a female physical therapist, and then they have a couple therapist. That's the best model in terms of dealing with problems. And I think one of the best ways of thinking about it is: physiologically, what promotes healthy sexuality, what subverts it? Psychologically, what promotes it, what subverts it? And relationally, what promotes it, what subverts it? You know, there was just a recent report from the veterans administration here in the states, that there's a four-fold increase of prescriptions for pro-erection medication for young veterans, and again the idea of the—my major objection to the biomedical model: it's asking the medication to do everything, to do more than it can do. You know my colleague Michael who just, as I said, died in March, dealt with cancer for seventeen years. He cared about his good relationship with his oncologist, but it couldn't be everything. He had to be an active patient. I'm an adult onset diabetic, I was diagnosed when I was twenty-nine. I have a good working relationship with my internist, but I've also got to look at exercise patterns, eating patterns, those kind of things. In good medicine, the integrative model is growing. In sexual medicine it's a standalone intervention. So, that's the argument. You know, let me give you one other thought. I know as a graduate student you probably are inundated with things to read and look at, but there's a new book that just came out called *The cultural context of sexual pleasure and problems*, it's edited by two psychologists, one from England, her name is Cynthia Graham—John Bancroft's wife—and the first author is Kathryn Hall. But one of the

Importance of referral network (Exp.)

BPS Model (Exp.)

Limitations of pharmacological Excessive expectations of pharmacology (Exp)

Virtual multidisciplinary team + Referral network used instead of on-site multi-disc. team. (Imp)

Need to integrate drug treatment w/ psychotherapy (Imp)

things that's so interesting is that it has all kinds of different cultures and how sex works or doesn't. And the best example of it is there's an extreme biomedical model in Iran, where he argues very strongly for the biomedical model, saying that's what works within the culture. And the European example is Portugal where, I think, it's two psychologists who talk about sociocultural things as well as relationship things and cognitions. So, I think it's a crucial issue, and part of what drives it is the drug companies and money.

MICHAEL: So, let me ask you this, in terms of reflecting on your own practice, or what you observed in terms of the actual shift experienced for someone working within a psychotherapeutic capacity—what changed with Viagra?

[redacted]: Well, I think what changed in a positive way is that you now had a medical intervention that would do two things: one is—serve as a positive placebo. And the second was that once the man is aroused, subjectively aroused, he'll maintain his erection longer. That's the pluses. The minus is that people wanted Viagra to do more than it could to. They wanted it to be a standalone intervention, they wanted it to give him back this idea of totally predictable, autonomous erections. And it couldn't do that. So that the drop out rate is actually—again, nobody writes about this, but the drop out rate is extremely high. And the men's sexual health clinics, which are these for-profit, terrible places, they've now given up with the pro-erection medications and they use injections. Injections—the more invasive the procedure the greater the efficacy, but the injections are very challenging to integrate into the couple's sexual style. And so I think, in the long run, the pro-erection medications have actually had a negative impact, even though they SHOULD have a positive impact.

MICHAEL: Due to the expectation that was placed on them that they simply cannot live up to?

[redacted]: Unrealistic performance expectation—and that's why Michael and I so emphasized the good enough sex model. The great majority of men in their teens and twenties—again, if I'm being redundant you've got to stop me, because I know you have your time—but the great majority of men who learn erection-intercourse-and-orgasm in a highly predictable, autonomous way—they don't need anything from their partner—and they see that as: that's the way. That's what real men do. That's the model in pornography, that's the model in movies. But that's not the truth. Real life couples, especially after age forty, but often even before age forty. That the reality is that sex by its nature tends to be variable, flexible, and have different roles and different meanings for people. And again, that's why I think desire plays such an important role. Because, you know in every sex movie you're going to see, it doesn't involve married couples, but it always involves the notion that both people are highly desirous, highly aroused, highly orgasmic. But again, if you look at real couples, both data-wise and clinically, that isn't the way it works at all. Couple sex tends to be really complex with different roles and different meanings.

MICHAEL: Absolutely. Now, I want to ask you a bit, if I may, about psychotherapeutic methodology. And in particular what I'm trying to drive at—and I have a tough time asking this question, or phrasing it in a way that I think captures what I'm trying to get—but I'm wondering about the therapeutic, the psychotherapeutic modalities that you used in treating male sexual dysfunction and in treating couple issues. What was it that you found useful in particular?

[redacted]: Well, I think that although they don't talk about it in a sexual way—I think of all the couple interventions, I am most fond of integrative behavior therapy. Andrew Christianson is the famous person in that—Christianson doesn't focus on sex at all. But I think this idea of starting with acceptance and then talking about change is crucial. I also think what is crucial in terms of the sex issues is to be able to talk about, directly with the client, their attitudes, their experiences, their emotions. And starting off with what works and then talking about what is dysfunctional and what they're trying to grow, and so there's two concepts that I would emphasize a lot when I would see couples. The one concept is the idea that the challenge for you all as a couple—and I think this is true, by the way, whether it's the male or the female that's having the difficulty, and I also think it's true, you know, lesbian couples do not come to male therapists, but I've seen a fair number of gay male couples, and non-married couples. And the challenge for couples is: how you integrate intimacy and eroticism into the same relationship. That's the real challenge. So we talk about what sexual style, what couple sexual style, works for you. That's one concept. And the other concept that I think is crucial—now again people don't always agree with this—David Schnarch, for example, thinks it's total bullshit. But I think this idea of these psychosexual skill exercises done at home between sessions, I think is—half the therapy, sexually, I think happens at their house, rather than in your office. But what the exercises do is—they give the couple a structure. It's not rigid like a cookbook, but it gives them a structure to really reengage. And then the other thing that I think is really important—you know, I'm tremendously respectful of the grandparents of the field, Masters and Johnson. And I'm tremendously respectful of their sensate-focus approach. But I think that for desire problems, or erection problems, or non-orgasmic problems, that you've got to focus specifically on the issue—how you build a comfortable, confident sexual desire. How you develop a sexual voice that allows you to focus on a pleasure, erotic flow, orgasm process. How you use ejaculatory control exercises. Now, again, for many, many men, using low doses of anti-depressants, or in Europe I think dapoxetine is available, right? It isn't available, it did not get through the FDA in the United States. But it's a perfect example. Doing it as a standalone, I think, makes no sense. Doing it as part of a program, as a couple program, to learn the skills of ejaculatory control, I think, makes tremendous sense. And then what I like to do for most of my clients is to fade out the medication. So, when I think about—again, I write about this stuff so much, but—in an actual, ongoing therapy session, I kind of divide it into three parts. The first part is: what did they experience? What did they learn positively in this last week or two about themselves as sexual people, as a sexual couple? What did they learn from the psychosexual skill exercises? And then

Sample Interview Transcript—Coding

talk about what was disappointing, or frustrating, or didn't work. And that is then a bridge to talk about this notion about who they are as people, who they are as a couple, in terms of their couple sexual style specifically. But, generally who they are as a couple. How much do they value intimacy? How much do they value eroticism? Are they a couple [for whom] sex is a big part of their lives, or it's a small part? And then the third part of the session is about what they're going to do in the next week or two. Whether it's an exercise, it's a reading, it's talking about something, it's a trying to come to grips with some tough issue from their past. So that's how I think about the sessions. Very seldom do my clients leave a session without a specific focus, or a specific psychosexual skill exercise.

MICHAEL: Now that leads into another question that I really wanted to ask you. It pertains to the setting of objectives for treatment, and the formulation of a treatment plan. And you've spoken to that a little bit. In your book, and in an article you co-wrote with Dr. Metz, you talk about the role that sex plays in the life of a couple. And in the article entitled, "The Good Enough Sex Model for Couple Sexual Satisfaction", you write, quote: "any approach to sexual dysfunction must recognize that, regardless of the causes, sexual dysfunction is a relationship problem affecting the emotional life of the couple". And I'm wondering, in light of that and with respect to the Good Enough sex model, if you can tell me about how you would go about setting objectives with the clients?

[redacted]: Well, what my objective, my overriding objective, is where sex—here's my mantra: intimacy, touching and sexuality. You want it to play a positive, integral role in your relationship. That's the overriding goal. And part of that, in terms of setting a plan, is being able to identify the negatives. I often talk to my clients about it—I call them 'poisons'. What are the poisons that subvert your healthy sexuality? But even more important: what do you need to do to rebuild a sense of healthy sexuality? You know, it's interesting, the last book that Michael wrote before he died is called *Enduring Desire*, [redacted], and it's written for couples. And it actually won an AASECT award as the best book of the year. Though it sells very few copies, it's interesting, it's hard to get people to think about this in terms of couples and prevention. But I thought—I was just looking at it before you called—and I thought that his notion where he says to the couple: what we're trying to help you do is to grow an intimate sexual relationship that really nurtures your bond. And again, most of the work in sex is done with married couples, but a lot of this is very applicable to serious non-married couples, and to gay couples. But I think the thing that is the most important in terms of treatment goals is that: it isn't a rigid thing, like number of intercourses, or number of orgasms. It is much more this notion that we've found a couple's sexual style that really fits us. That allows us to feel, and I know I'm being redundant here, desired and desirable, that energizes our bond. And my objection to so much of the biomedical sex therapy literature, sex literature, is it's a very individualized, very performance-oriented model, where I think of this approach, the Good Enough Sex approach, as couple-oriented, as variable and flexible, and the idea that it's ok that people have different roles and meanings for sexual experiences. You know, the thing that I'm

writing about more now, and talking about more when I do workshops, is the idea of the value of both synchronous sexual experience—in other words, where both people are desirous, they're both aroused, they're both orgasmic, they feel really good and bonded as a couple—but also an acceptance of asynchronous sexual experiences, where the experience has a different role and meaning for one partner than the other, where it's better for one partner than the other, as long as it isn't at the expense of the partner or the relationship. And I think that that's something that is not discussed very much at all in the sex therapy literature, or the couple therapy literature, about: what is the healthy role of both synchronous and asynchronous sexuality? So, another thought.

MICHAEL: Right, and I don't mean—and this is not one of the questions for my research, and I don't mean for it to be a fatuous question—but it's something that I always wonder about and rarely have the courage to ask. And that's: with respect to couples who just are not attracted to each other? Where they're just devoid of sexual attraction to one another—how would you deal with that?

[redacted]: Well, I think that's a very common issue. And again, let me give you the serious answer to it, not the simple answer. You know, I think for the majority of couples, and I really mean the majority of couples, they have a period somewhere between six months to a couple of years that is kind of a: romantic love, passionate sex, idealization period. It's a wonderful period, and it doesn't last, no matter how loving or sexually functional they are. The challenge for them is to develop a way of approaching sex and sexual desire that really is going to work for them in an ongoing relationship, and for so many couples they never do that. And what actually happens for them, I think, and I think this is the key element in couples where they have lost desire for each other, is they have a way of being sexual that is not inviting to either one, and it's usually not inviting to the woman. So they get into a routine where sex is intercourse-focused, not pleasure-focused. Now, in terms of rebuilding desire, I think for the majority of people that is very doable. There is one exception to it. And this is something I think is important. And that is: there are some couples who marry or go together specifically for anti-erotic reasons. And when that happens, I think it's almost impossible to rebuild desire. But I think for the great majority of couples rekindling or rebuilding desire is not only possible, but it's preferable, and that the key to doing that is finding a new couple sexuality that, again, integrates intimacy, pleasure and eroticism. You know, let me give you two examples. They're both extreme, they're very interesting. The one negative is: a couple who came in, they came from an orthodox Jewish background, and they married young and that was expected in their community, and everybody in the community was very in favour of them as a couple—family, friends, everybody. And they came in because she was objecting they weren't having sex very often, and he desperately wanted her to get pregnant, she wanted to go to graduate school. And in doing the individual history, what came out is that the man wanted to have kids so that it would tie her to the marriage, because that was expected in his religious community. But the fact is that he had never been—in his whole sexual life, including with her—attracted to Jewish women. For him,

eroticism, he would never have sex, never have an affair, with a Jewish woman, but for him eroticism and affairs were all about non-Jewish women (I think it's called shiksas, or gentiles, I can't remember what it's called). And that was totally unknown to her. Now that was a couple where, my guess is, no matter what the intervention, it wasn't going to be helpful. But the much more common issue is the issue where you get this couple who really felt very loving and very attracted, sex went really well, was very exciting, functional, and then they get into a pattern—and it isn't having a child, although certainly that can be an issue—it's the idea that every time that they touch they're going to go to have intercourse. And so they lose that sense of vitality, of unpredictability, of playfulness. And the sex might be functional for the man, it usually becomes dysfunctional for the woman, but not always, but even if it's functional it isn't energizing for her. She doesn't desire. So once she becomes involved sexually, she might be aroused and orgasmic, but she doesn't feel desire. And that's the problem I see a tremendous amount, and that's where I think the function, focus on desire, and so sex is something to anticipate. That's where I think the interventions are so important. And again my mantra—it comes from Sally Folley's work—is you've got to find the right degree of intimacy, the emphasis on non-demand pleasuring, and then finding erotic scenarios and techniques that add vitality, and unpredictability, and that sense of bonding and satisfaction. So, I think that the problem that you're raising is the most common, typical problem, about desire.

MICHAEL: Well it's been, I've seen it articulated in many of my interviews, and I think that there are arguments about neurobiology and neurology that are mobilized with respect to—oxytocin, and intimacy. And that there is this—perceived to be a fundamental antithesis, a tension between intimacy and sexual desire that seems very difficult to reconcile: that once you have mobilized or activated the intimacy system you have foreclosed on the possibility of desire, and it seems like a real conundrum to me.

[redacted]: Well, I think it's a challenge. One of the people who writes the best about it is Esther Perel—intimacy and eroticism being totally different. I think she's absolutely right about that, that they are different. But that's what the challenge is. Because when you think about intimacy, I think what intimacy's all about is warmth, closeness, predictability, feeling loving, feeling accepted. When I think about eroticism, what I think about eroticism is: it's all about unpredictability, taking personal and sexual risks, just that sense of being turned on and vital. Those are very different phenomena. Again, I think the question is: if you believe, as I do, that for the majority of people—the majority of people would like a satisfying, stable sexual relationship. Now that isn't everybody, there are some people who really emphasize satisfaction, but not stability. There are people who emphasize stability but not sexuality. But when I think of healthy relationship—it integrates satisfaction, stability and sexuality. And I think if you're going to do that, you've got to integrate intimacy and eroticism. And again I think in terms of therapy, part of that is talking about it in the session, part of it is giving them homework assignments that can be based on reading material, but it can also be based on their

looking at their own lives with each other: what was their most intimate experience? What was their most erotic experience? I don't think intimacy and eroticism are adversarial. I think they can be complimentary, but they're certainly different.

MICHAEL: Yeah, absolutely. So they're not inherently at odds with one another.

[redacted]: Right. They're not adversarial, but they're different.

MICHAEL: Good, ok. Now there are three more questions I'm hoping to ask you—is it ok, I've taken about 40 minutes of your time, is it ok if we go for another 10 minutes?

[redacted]: Sure, that's fine.

MICHAEL: Great, now I wanted to ask you—one of them is a very simple question, and I think the other two are a little more complex. I wanted to ask you about diagnostic procedure. I have a sense of sort of—I believe I have a sense of how you would do diagnosis in clinical practice, but I also wanted to get your thoughts a little bit more on that—on the diagnostic categories. On the utility—on what's good about them, on what's bad about the diagnostic categories. Your perception of their validity and what do they actually measure? And also: questionnaires or instruments—if you have found those to be useful?

[redacted]: Well, you know, it's an interesting split between Michael Metz and I, in that what he would do is that he would use paper and pencil tests, and what I do is just the interviews. What I think is important, in terms of the new DSM-V categories is that: I tend to side with Rosemary Basson in saying that: for females, subjective arousal and desire are very closely tied, that they're not separate phenomenon. I think that for males it is valuable to make the differentiation between desire problems, arousal problems, and orgasm problems. But again I don't think it's like in medicine where they're totally separate categories. They're often quite correlated categories. One of the things that I'm not happy with, in terms of DSM-V is their emphasis on hypoactive sexual desire disorder, that emphasizes masturbation and erotic fantasies and erotic dreams. I don't think that that's the best emphasis. But again it's a medical emphasis. So that's my answer to that one.

MICHAEL: Ok, ok. And if I may ask you—and this is a little bit of a slight tangent that pertains to diagnosis. Would you be willing to share some of your thoughts on the omission of hypersexuality as a diagnosis?

[redacted]: Well, I do think that this emphasis about Carnes and sexual addiction is the wrong way to go. I think that—I think it can certainly be a major problem, but I think the way to think about it is much more this idea of: an impulsive-compulsive pattern, and the thing that I believe the most about males and hypersexuality is: the issue is this combination of secrecy, eroticism and shame.

That you put those three together and you have a poisonous pattern. So I think—you know, if you buy the notion of the difference between variant arousal and deviant arousal—I think variant arousal is four or five times more common than deviant arousal. Deviant arousal, obviously, is much more serious because it hurts other people and it's illegal. But I still don't—the sex addiction model, I do not believe is the best way of going. And I think one of the reasons they didn't put hypersexuality in is because it's so controlled by the sex addiction model.

MICHAEL: Right, yeah, absolutely. So, is it safe to say, and am I right in understanding, it would be more a matter of impulsivity and compulsivity—is it only incidentally sexual then?

[redacted]: No, I think it is very sexual, but it's a very narrow, eroticism-based sexuality. Not an integrative sexuality. And for most people it's very difficult to integrate whatever they're doing compulsively sexually into an ongoing sexual relationship.

MICHAEL: Yeah, ok, ok. Now, the other thing I wanted to ask you is, with respect to progress—and this might refer back to your perception of diagnosis and the difference between you and Dr. Metz in terms of using a verbal interview versus using physical instruments—but I'm wondering how you measure progress over the course of therapy, how you would know that things are progressing well, and so on.

[redacted]: Well, again, I think it's a combination of self-report, but also keeping data. Keeping whether it's diary data, it's a—you know the great advantage of seeing the couple together is they're not going to collude. They're much more likely to be blunt with each other about what's going well and what's going badly. But I think that one of the most valuable kinds of things about trying to measure progress is whether both partners have a similar view about desire, pleasure, eroticism and satisfaction. So, it isn't like—the best way to understand—you know if you think about the CBT model, one of the things that is valuable in the CBT model is that you're often looking at very specific behaviors, and keeping track of those behaviors. I think a better way of seeing it is: the integrative behavioral therapy approach. It's that the most important variable is this acceptance and satisfaction rather than specific behavioral numbers. And I think that the, again, the best measure is where the couple are congruent in their evaluations, and it's about desire and satisfaction.

MICHAEL: So how would you ask them about that?

[redacted]: One of the best ways to ask them about that would be to do it exactly that way. As: when you think about your sexual relationship, what is this, January? How does your approach to sexuality and sexual desire look in January, as opposed to when we started in September? What is your experience in terms of pleasure in January as opposed to September? What is your experience in terms of eroticism, feeling subjectively aroused in January versus September? And how

satisfied are you about yourself as a sexual person and you two as a sexual couple? Are you 100% there, 80% there, 50% there? Or it's gotten worse?

MICHAEL: That's helpful to me. That sheds light on things. And the reason that I say that is that—this is one of the questions that I ask everybody, and I have been having such a difficult time trying to. And I think I've been having a difficult time in that I do not yet have a clinical practice, and so I don't have that kind of insider perspective. But it's been really tough, because I've asked: how do you measure progress? And the response that I generally get is: well I ask the couple how you're doing. And it's tough for me to visualize what that means, and so to have the sense you've given me of specific questions is actually quite useful to me—thank you. Now the one final question I would like to pose, because it's near and dear to my heart—it pertains to sort of my early life inspirations for studying psychology in the first place—but pertains to the role of psychodynamic methods. And I'm sort of, when I start to think about this within the field of sexual therapy, and within the field of sexual health, I think of course of Helen Singer Kaplan's work, and her position cognitive and behavioral interventions in a place of primacy: that you start there, and once you start to run into roadblocks, then you would delve into psychodynamic methods. But I wanted to get your sense, from your research and from your experience, of IF there is a place for psychodynamic methods, and what that place might be.

[redacted]: Well, let me answer in two ways: right now, in terms of living people, the best writer/speaker about psychodynamic couple sex therapy is a guy named Steve Levine—who's a psychiatrist based at Case Western, based in Cleveland. And he does a tremendous amount of writing about psychodynamic sex therapy. He's a very smart, very nice guy, and really believes in it. Now, for me, there isn't a psychodynamic bone in my body. So, what I think is important, though, in terms of the translation, is understanding the different experiences and meanings of sexuality that people have. Whether it's from the culture, from their family, from childhood sexual trauma. So I think that I would, instead of using a psychodynamic model, my model is more the model of processing your experiences, in terms of healthy learnings, and in terms of poisonous learnings. That's what I emphasize with folks. So in my system, psychodynamic approaches are not well utilized. But if you really want to get a sense of it, the person to read is Steve Levine.

MICHAEL: Yeah, I've read some of his work, I haven't had—and I knew he spoke of it to a certain extent, but I'll dig in a little further and find out where he speaks about it more concertedly, because I haven't—that's one of the things that I find slipping through my fingers: who is using this? Is anybody finding this useful? And actually, anecdotally, I have found that there's a very different perspective within the psychology field within the UK versus the North American psychology field, with their relationship towards psychodynamic practice. There's much more emphasis on it over here.

Sample Interview Transcript—Coding

[redacted]: Well, in the United States, believe it or not—I mean if you were to ask me: what is the theory that is most impactful, it's still psychodynamic. It's not the traditional Freudian psychodynamic, but it is a psychodynamic approach.

MICHAEL: Really?

[redacted]: I mean, in the group that I practiced in—it was a six person practice, everybody was a psychologist. And some of them worked in the sex field, some of them didn't. But probably of the six of them, five would say that their major theoretical approach was psychodynamic.

MICHAEL: Is that right?

[redacted]: Yep.

MICHAEL: Wow—that's interesting.

[redacted]: Now, again, that is less true of younger clinicians, but it's still more—and part of the reason for that is when clinicians go into therapy themselves, they often go into therapy with a psychodynamic person, and that has a big influence over them.

MICHAEL: Yeah, yeah absolutely. Ok, great, that absolutely covers the main questions I wanted to cover, and I should say.

[redacted]: Good luck with your dissertation.

MICHAEL: Well thanks very much.

Table 5.2

Biopsychosocial and integrative treatment orientation: number and percent of interviewees discussing themes/sub-themes explicitly and implicitly

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Clinician emphasizes/utilizes a biopsychosocial Orientation		16	47.1	3	8.8
	Interviewee expresses holistic view of client	5	14.7	3	8.8
	Interviewee stresses the importance of embodiment in sexuality and treatment	6	17.6	0	0
	Sexual dysfunction is a possible marker or symptom of physical illness	4	11.8	1	2.9
	Interviewee recommends recommends/refers for early medical screening	9	26.5	0	0
Clinician emphasizes/endorses an integrative (i.e. biopsychosocial) approach to treatment		13	38.2	2	5.9
	Limitations of an exclusively medical approach	3	8.8	1	2.9

Table 5.2 (Continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Medical-only treatment may foster unrealistic patient expectations	1	2.9	0	0
	Type of client concern dependent on referral pathway	2	5.9	0	0
Multidisciplinary (on-site) facility used or seen as ideal treatment model		5	14.7	0	0
	Referral network used in lieu of integrative/ multidisciplinary facilities	5	14.7	1	2.9
	Interviewee stresses the importance of referral network (and need for diverse, well qualified professionals within)	13	38.2	1	2.9
Interviewee emphasizes limitations of pharmacotherapy		4	11.8	0	0
	Clinician emphasizes the value of combination therapy model	2	5.9	0	0

Table 5.2 (Continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Essential to integrate drug therapy with other therapy (i.e. couple/sexual therapy or psychotherapy)	4	11.8	0	0
	Male has control over timing of sex, due to pharmacological interventions	1	2.9	0	0
	Drug therapies may cause psychological/ relational problems	3	8.8	0	0
	Risk of psychological dependence on drug therapy	2	5.9	0	0
	Patient/client demand for a medical/ pharmacological treatment	2	5.9	1	2.9
	Patients/clients have unrealistic expectations about drug therapies	2	5.9	2	5.9
	High dropout rate for drug therapies (i.e. as monotherapy)	2	5.9	0	0
	Increased number of older clients observed due to pharmacological/medical advancements	1	2.9	0	0

Table 5.2 (Continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Introduction of drug treatments drew attention to sexual health issues and/or increased number of men treated	1	2.9	1	2.9
	Involving partner in pharmacotherapy should be a priority for clinician	1	2.9	0	0
Clinician uses psychotherapy integration (i.e. integration of different schools/models in ST practice)		21	61.8	0	0
	Movement towards methodological integration (i.e. of psychotherapy models used), through professional development	1	2.9	0	0
	Technique/method chosen in vivo, based on current assessment of client needs	11	32.4	1	2.9
	Integrating psychodynamic and CBT seen as beneficial	8	23.5	1	2.9
	Clinician interweaves psychodynamic and CBT (i.e. non sequential)	4	11.8	2	5.9

Table 5.2 (Continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Clinician uses psychodynamic techniques to overcome 'blocks' where CBT proves inadequate	5	14.7	1	2.9
	Sex therapy in UK seen as more integrative than USA	1	2.9	0	0

Table 5.3

Biopsychosocial and integrative treatment orientation: themes and sub-themes identified in research interviews, including representative/characteristic statements

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician emphasizes/utilizes a biopsychosocial orientation	19	55.9	the sexuality field is multidisciplinary and it has to be multi-approach. We have to bring in the biological, and the psychological, and the cultural, social, linguistic, everything has to come in. I work from a model of human behavior which says that all behavior, including sexual behavior is the result of a dynamic interaction process between biological factors, psychological factors, and socio-cultural factors, keeping in mind that each of those broad categories has multiple levels... This is a kind of mutual thing where each of those factors is interacting at the same time with each other. it's really a range of things that `I look for…in terms of how physical, versus psychological, versus relational it is.
Interviewee expresses holistic view of client	8	23.5	to me, the sexual issues are going be part of a much more holistic point of view. I address [physical and psychosocial] issues because I see people as holistic organisms in that sense. we have to think from a multi-systemic, holistic perspective, and that can only happen by being curious, as opposed to assuming there's a fixed point of mental, physical and emotional health. I started, probably from quite an integrated approach. So, a biopsychosocial approach.

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee stresses the importance of embodiment in sexuality and treatment	6	17.6	the way I see it is: between the cognitive and the behavioral is the body, and to simply change the way you think as a way of changing behavior, to me, is insufficient. So when I start to move from the cognitive into the body, into an awareness of the body, that's where [gestalt and mindfulness practices] come into play. I ask people to stand and move and step into, literally, step into their experiences, step into the physical aspect of that story, step into the emotional aspect of that story, or the mental, cultural aspect of that story, or the spiritual connection aspect of that story. And in the stepping in there is very often an embodied sense of memory.

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Sexual dysfunction is a possible marker or symptom of physical illness	5	14.7	it's not all psychological, I mean, we know if men don't wake up with erections in the morning, according to the New England Journal of Medicine, within six months there's an eighty percent likelihood that they're going to have a cardio or neurological event. So, not being able to wake up with an erection isn't necessarily about how enraged the person is with their partner. It could be an indicator that there are physiological issues that need to be dealt with. there are some –particularly for erectile dysfunction...there are certainly some medical conditions where that's a silent marker for a cardiological problem, or maybe diabetes. So, it's useful to know that somebody who, say, was finding it easy to get an erection is now suddenly finding it very difficult. And you want him to be checked out medically. it's important that we link-in with medical assessors to check out that, before we start working, or alongside our working, that the appropriate medical investigations and treatments happen. Not just because it might be linked to sexual problems, but because like I said it can be a symptom of more problematic medical problems.

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee recommends recommends/refers for early medical screening	9	26.5	I suggest before I see them that they actually go and see their GP, and I explain that... you've got to eliminate any physical causes, because you can work with them for years and years, but if there's a physical cause you can't do anything about it [with psychotherapy]. As a matter of routine, I would refer clients to have a medical checkup, even if there's no reason to believe that there's any problem I would ask them to get some standard tests done, just to sort things out.
Clinician emphasizes/ endorses an integrative (i.e. biopsychosocial) approach to treatment	15	44.1	the model that we use...takes a very integrated relationship focus...we don't believe that it's possible to look at sexual dysfunction in isolation of the relationship and social and cultural factors, as well as obviously psychological and biological, physical factors. an integrated approach can be helpful because there isn't a prescription that works for everyone. obviously the biopsychosocial approach is an integrative approach. It wouldn't work otherwise, [it's] absolutely crucial.

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Limitations of an exclusively medical approach	4	11.8	we've been narrowing down, further and further, towards a medical model of sexuality, which is shocking, but that's the way it is. And so I try to broaden my [perspective] out, and say: look you've got to stand back and look at the broad picture of all the different things. one of the problems with ED treatments is that, in the clinical setting, the patient may have, say, had a prostatectomy, lost the nerves, no longer has erections, or lost some of the nerves, no longer has full erections. And in the clinical setting they may come up with an ED treatment that raises—on a 1 to 10 scale—raises what used to be a 10, is now 1 or 2, back up to 7 or 8. And they can see that in the doctor's office as a success. Improvement above the bottom. But, seen from the patient's perspective, if it used to be a 10, and it's now a 7 or 8, every time they have sex they're reminded of what they've lost. my objection to so much of the biomedical sex therapy literature is it's a very individualized, very performance-oriented model.
Medical-only treatment may foster unrealistic patient expectations	1	2.9	too often what happens...is we offer the guys erectile dysfunction treatments, as if to say 'we'll make you the man you were before; you don't have to grieve loss, because you'll be exactly what you were before, and too often they fail.

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Type of client concern dependent on referral pathway	2	5.9	[You should] consider where my primary source of referrals were--I think that's something, if you don't ask when you interview people, you need to ask them, because that does make a difference. as I moved into different settings, my source of referrals changed the nature of sexual complaints. When you're in an independent practice, [the clinical issue] depends on who's referring.
Multidisciplinary (on-site) facility used or seen as ideal treatment model	5	14.7	because we [members of referral network] work in separate places it doesn't work brilliantly…the idea of working in the same building--that would be a good revolution to have. My ideal working place would be some sort of center, a holistic health and wellbeing center where I'd have free access, easy access to dermatologists, gynecologists, obstetrician, urologists, blood tests [etc.].
Referral network used in lieu of integrative/ multidisciplinary facilities	6	17.6	It's very difficult to achieve [multidisciplinary integration] because of the way that health services are set up…I will certainly sometimes ring up a GP…and similarly we have a very good urologist, and an andrologist [within referral network].

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee stresses the importance of referral network (and need for diverse, well qualified professionals within)	14	41.2	Part of how I train other people is...to get them to establish and define their network of support, and their network of referral...it's your responsibility to know: who would be a competent gynecologist, urologist, endocrinologist, massage therapist [etc.]? obviously the biopsychosocial approach is an integrative approach. It wouldn't work otherwise. Absolutely crucial. Yep. Referrals in and out to GPs, dermatologists, urologists, gynecologists, obstetricians…those networks are crucial.
Interviewee emphasizes limitations of pharmacotherapy	4	11.8	They would talk about: "what can I do to improve my erection?" But when you talk about what the problem was, it wasn't something that Viagra or Cialis was going to fix—it was low desire, maybe, based on a poor relationship, or maybe just what was, quote 'normal'. I love a quote by Dr. Ruth…she said: "Viagra doesn't work if you didn't take out the garbage" we have a tendency to want to put a label on something and come up with a simple solution. Rather than understanding: where does this problem, whatever it might be, where does that come from? And that's why in many cases, and I point this out to clients in the beginning, medication may not even be an issue. And it then gives them control over what they do. It isn't some outside factor that they have to go to, they have to take this pill in order to correct this, or deal with this issue. So, rarely, I have to say, over the years, have clients needed some type of medication in addition to their therapy.

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician emphasizes the value of combination therapy model	2	5.9	When Viagra first came out, people talked about it as: oh, you know, this is going to put me out of business. I remember one urologist telling me that. Well, far from that. It actually increased, because what happened? A lot of guys would use it and then found out it didn't work, and then they would go into a total state of panic. unfortunately we have seen [an emphasis on medicine over psychology] in sexual dysfunction. Definitely. So, however, there's been an acting movement within psychology to proclaim our added value in general. So you have [psychological researchers] talking about combination therapies and the importance of it and within psychology.
Essential to integrate drug therapy with other therapy (i.e. couple/ sexual therapy or psychotherapy)	4	11.8	the people who have the time to treat couples [are] couples counselors, and sex therapists, are typically not MDs. Psychiatrists don't spend a lot of time in this area, they would be the one exception, but because psychiatrists aren't doing a lot of couples counseling because it takes a lot of time....[so] those who are doing the couples counseling aren't free to write up prescriptions for Viagra. So, we're—the whole medical system—is not well-designed... Those who offer chat discussion, and talk therapies...they're not prescribing, and I'm arguing that we need to bring the two together. Because, in fact, that is the way to get the therapies to work—by merging them in the mind of each individual.

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Male has control over timing of sex, due to pharmacological interventions	1	2.9	we've had a lot of pharmaceutical and medical interventions regarding particularly male sexual dysfunction [and]...suddenly it's the man [who] has all the control, if you like, over when they will have sexual intercourse, because he has to take the pill
Drug therapies may cause psychological/ relational problems	3	8.8	when I first started, I used to say to my clients: I wish there were a magic pill. I wish there were a pill I could tell you about that would allow you to get it up and keep it up. And then along came the magic pill that everyone was looking for, and it creates just as many problems as it solves. All of a sudden, accommodations that have been made to this unhappy situation fall apart, and we look at the fact that one of them really doesn't want that kind of intimacy. Or, now that they CAN do it, they don't want to do it with the partner they have. And various other things that really cause problems.
Risk of psychological dependence on drug therapy	2	5.9	I am finding recently that there seems to be a reliance on the Viagra-like drugs...that people feel reliant on them. a huge number of young guys use Viagra as a security blanket. And there's been one paper recently published which showed that this is a sort of socially addictive situation. They were so dependent on the Viagra. Whether it was really working physiologically or not, and whether they were actually getting real drugs or fake drugs, their confidence was so dependent on it.

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Patient/client demand for a medical/ pharmacological treatment	3	8.8	they are coming to you with an anti psychological/complimentary alternative medicine bias already. They want the creams the lotions and pills because they do not want to be told "this is all in your head".
Patients/clients have unrealistic expectations about drug therapies	4	11.8	The minus is that people wanted Viagra to do more than it could to. They wanted it to be a standalone intervention, they wanted it to give him back this idea of totally predictable, autonomous erections. And it couldn't do that. So that the drop out rate is actually—again, nobody writes about this, but the drop out rate is extremely high.
High dropout rate for drug therapies (i.e. as monotherapy)	2	5.9	Something like 40% of all people who initially get a prescription of Viagra aren't using it two years later…we also know that, even though they're initially effective, even penile injections--intracavernosal injections--which are effective in the doctor's office, don't necessarily have a sustained use two years out...and the question then is: why not?
Increased number of older clients observed due to pharmacological/ medical advancements	1	2.9	in the last perhaps two years I've probably seen a lot more older clients in sex therapy... I think there's something about the fact that couples are living longer, individuals are living longer [and] we've had a lot of pharmaceutical and medical interventions

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Introduction of drug treatments drew attention to sexual health issues and/or increased number of men treated	2	5.9	within the area of male sexual dysfunction, the whole development of medical interventions, particularly drugs, have led to the referral of men into the psychosexual, sexual medicine system, who wouldn't have [been referred] before
Involving partner in pharmacotherapy should be a priority for clinician	1	2.9	I heard one of my colleagues tell me this story...about how he gave a prescription for Viagra to a patient, and the patient came back later, and when he asked if it worked or not, the patient said "no". The physician friend said "why", the patient said "well, I tried it, but she wasn't into it"...And it led me to think that really what was missing was the integration of the partner into the prescription, literally. So one of the things that I thought we should be doing is actually prescribing the drugs to the couple.
Clinician uses psychotherapy integration (i.e. integration of different schools/models in ST practice)	21	61.8	you can't do sexual therapy with just CBT and sensate focus. And I'm afraid there are heaps of people who do that...[But] the therapy is a much deeper level where you have to really bring in, you have to fit the therapy style to the client, not the other way around, which is what a lot of those formula things do. Cognitive therapy...along with anything else that seems useful at the moment. [The technique used] varies according to the person I'm sitting with...The primary place that I come from is one of intersubjectivity. So, if you can imagine contemporary psychoanalytic thought with a focus on the relationship, with a strong aspect of systemic thinking. That would be my primary modality.

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Movement towards methodological integration (i.e. of psychotherapy models used), through professional development	1	2.9	I've been a sex therapist for over 35 years, and a psychotherapist for forty years. And what happens is that everything gets blended and your treatment becomes quite eclectic, so it's hard to, you know, identify. I mean I started out trained in psychodynamic psychotherapy, and then I had training in marriage and family therapy, and then I had training in sex therapy. And so, I incorporate cognitive techniques, behavioral techniques, and at the same time when I'm working with a couple, if there are resistances and difficulties, I'm also sensitive to their history, and how their families of origin have shaped their expectations, or their reactions.
Technique/method chosen in vivo, based on current assessment of client needs	12	35.3	I try to tailor the treatment to what makes sense for an individual person. So I don't start out with a cookbook approach. in terms of techniques, I bring them into play when they're useful. When it suits a particular situation and couple. I would call myself an integrative therapist...it will come to mind for me--in relation to a patient--that there is something useful at a moment in time, as a way of helping an individual understand. I'm now talking about the sort of micro-management, say, on a sessional basis. I want the therapy to be based upon the individual situation the patient finds himself or herself in, rather than a set of techniques

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Integrating psychodynamic and CBT seen as beneficial	9	26.5	I see myself as operating...within an integrative model—using CBT and systemic theory, as well as psychodynamic. The CBT approach is really helpful because it can help you look at the steps in the behaviour process…But also you need that sort of unconscious awareness of why are you doing this, what is it filling for you, what is the need here? the psychodynamic aspects...the unconscious processes, and helping people to become more aware of previous influences [are useful], but then ...the really good thing about CBT is it gives you good, good, good tools for helping people manage anxiety, manage in-the-moment changes of behaviour.
Clinician interweaves psychodynamic and CBT (i.e. non sequential)	6	17.6	couples can have all the insight and understanding about why they've got this problem, what it is, where it's coming from and so on—it hasn't necessarily changed the behaviour. You can also give them a straight CBT program and for a time, maybe change the behaviour because they're kind of doing as you're telling them to. But it doesn't shift the underlying psychodynamic issues, so they may well regress. So... we would use the CBT programs in order to reconnect the couple [goal], and to work on specific dysfunctions. But actually those exercises themselves bring up the psychodynamic issues in any case, so then you would work with those as well. So we weave between the two.

Table 5.3 (Continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician uses psychodynamic techniques to overcome 'blocks' where CBT proves inadequate	6	17.6	with defenses, they're there for a good reason. And I will often, if I'm aware of it, talk quite directly about some particular block. I mean, Kaplan will talk about, when you're setting exercises and so on, the repetition, bypass or interpretation, and I think that's quite a good guideline. it very much depends on what the client's trying to achieve. If the client wants a fix, now, in the here and now, I would probably use CBT techniques... I can go either way, I can work in the here-and-now with the presenting problem, or I can go back and look at root cause...I might say: "ok, well, yeah, I can do cognitive behavioural work to fix it, but if we get to a block we may have to go back, in order to understand more, in order to go forward".
Sex therapy in UK seen as more integrative than USA	1	2.9	I guess I'm aware [of] the importance of sexology in the States, and how that shapes things differently from here [in the UK]...I think there are purer models in the states. I get the impression that there are more people working purely CBT [or] purely systemically. Whereas I come across very few people who don't use some kind of integrative model here.

Table 5.6

Couple and relational issues in sex therapy: number and percent of interviewees discussing themes/sub-themes explicitly and implicitly

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Clinician conceptualizes the problem in a social/interrelational way (esp. focusing on couple relationship)		16	47.1	0	0
	Emphasizes advantages of framing the problem as a couple issue	8	23.5	2	5.9
	Clinician seeks to identify the nominated 'carrier' of the problem within the couple	2	5.9	0	0
	Blame (between couple members) seen as a key factor in sexual problems & treatment	4	11.8	2	5.9
	Non-sexual relational problems may present as (or intensify) sexual problems	10	29.4	3	8.8
	Communication (esp. between partners) seen as a mediating variable in sexual functioning/satisfaction; improved communication sought	10	29.4	3	8.8

Table 5.6 (Continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Difference in levels of desire (between couple members) seen as common concern	8	23.5	1	2.9
	Interviewee emphasizes the value of accepting asynchronous sexual experience (different experience for both partners)	2	5.9	0	0
	Interviewee indicates 'honeymoon' phase of high desire, evolving into less sexual phase, as typical relationship progression	3	8.8	0	0
	Clinician uses a systemic psychotherapy/ sex therapy orientation	5	14.7	0	0
Clinician uses a couple-based treatment approach (i.e. actively involving both couple members)		11	32.4	1	2.9
	Clinician uses, or emphasizes use of, psychoeducation	19	55.9	0	0

Table 5.6 (Continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Couple relationship must be stable/robust enough for sex therapy (i.e. potential for cooperation and communication)	7	20.6	2	5.9
	Clinician views behavioural interventions as more effective with client in a stable relationship (as opposed to single client, or client in an unstable relationship)	3	8.8	0	0
	Interviewee frames couple/relationship counselling as distinct from sex therapy	8	23.5	0	0
	Relationship therapy may be required before sex therapy	2	5.9	0	0
	Working with couple together has unique challenges (as opposed to working with individual)	1	2.9	0	0
	Interviewee emphasizes that couple counselling overlaps with sex therapy	6	17.6	1	2.9

Table 5.6 (Continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Interviewee emphasizes importance of seeing both members of a couple during assessment		11	32.4	1	2.9
	Clinician sees couple members together and separately during assessment	9	26.5	0	0
	Couple members may have secrets in relation to one another	4	11.8	1	2.9
	It may be possible for couple members to be more honest during individual meeting with therapist	4	11.8	0	0
	Clinician works to identify divergent values between couple members, or conflicting beliefs about sex	2	5.9	0	0
	Interviewee states that the individual within couple should take responsibility for personal sexuality	2	5.9	2	5.9

Table 5.6 (Continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Interviewee stresses importance of relational intimacy for sexual functioning		4	11.8	3	8.8
	Reconnecting the couple, or building intimacy, stated as explicit overarching goal	4	11.8	0	0
	Difference/tension between intimacy and eroticism	1	2.9	1	2.9
	Fundamental challenge/aim: integrating intimacy and eroticism into the relationship	2	5.9	1	2.9
	Feelings of ambivalence (about sex) are often present in couples	1	2.9	0	0
	Something initially attractive about partner becomes frustrating in couple relationship	1	2.9	0	0
	Interviewee emphasizes the damaging effects of ongoing rejection by one partner	1	2.9	0	0

Table 5.7

Couple and relational issues in the treatment of sexual problems: themes and sub-themes identified in research interviews, including representative/characteristic statements

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician conceptualizes the problem in a social/ interrelational way (esp. focusing on couple relationship)	16	47.1	the main thing is to—I think as little as possible put something in a confined box, and work with the whole experience of the couple I think that this more integrative approach, and especially that looks at the couple dynamics, and the interaction between attitudes, behaviors and emotions is so important. Now, the reason I think desire is a major issue is: when you look at the studies—not biological studies, but couple studies...it's this one-two combination: you take personal responsibility for yourself but then to change the problem really takes the two of you working together. we would be thinking very much about trying, where possible, to frame it as a couple issue, rather than an individual issue, and bearing in mind what we know about couple dynamics.
Emphasizes advantages of framing the problem as a couple issue	10	29.4	first of all, I would find out about the relationship, the quality of the relationship. Because often as a couple start to see each other more, and notice one another more, and become curious about each other, then if there's a desire problem, sex can start to happen as they become more curious and interested in one another, rather than adopting very rigid positions of: "I know what he's going to say, and I don't want to listen" or "I know what she's like. She's always nagging and I'm not going to listen". to be able to frame it as a couple issue, takes the weight of responsibility off this one person who's feeling like "it's all my fault", and the other person is feeling quite disempowered about it, it makes it feel more like a joint thing that they can work on together.

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician seeks to identify the nominated 'carrier' of the problem within the couple	2	5.9	I would ask both of them to say what they hoped to gain. Usually one of them was saying "fix her" or "fix him" because we're not having the kind of sex life we want. And the other one was saying, essentially, "get her, or get him off my back". As the treatment process began to unfurl, it became evident that actually underlying a lot of this—it had been the male partner presented as 'the problem', and so often it isn't the presenting partner who's the problem, it's the other partner who's holding all the anxiety or dysfunction in the relationship.
Blame (between couple members) seen as a key factor in sexual problems & treatment	6	17.6	it's a lot of blaming [in] couple work. So, you know, it's all: "if he'd change" or "if she'd change, we'd be alright", "if you could get her to do this we'd be fine". I think one of the hardest issues is seeing people who are really demoralized and are into this blame-counter-blame cycle. people would say...: "well, I came in initially thinking you would fix her, or fix him, and you helped me understand that this is a couple problem, and it doesn't mean I'm wrong or he's wrong". And I always felt, if they went away with that comment, then I felt, ok the therapy was a success.

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Non-sexual relational problems may present as (or intensify) sexual problems	13	38.2	Often when couples come about a sexual problem, they have got other problems as well. The problem—the apparent symptom—may be sex, but actually that isn't the problem, it's something else. the sexual difficulty is really a reflection of the emotional relationship...this is often the case. I like to tell people that the sexual relationship is very much the non-verbal dance that describes the emotional relationship. often when you have a presented sexual problem, it turns out to be more of a relationship issue than a sexual one, so it's very important to look at the broad scope of things. I'd say the majority of the—quote—"no interest in sex" was poor relationships, and they needed more general couple counseling than they needed any specific sex therapy skills.
Communication (esp. between partners) seen as a mediating variable in sexual functioning/ satisfaction; improved communication sought	13	38.2	I will look for things that perhaps are maintaining the problem, and that might be: a lack of communication. That might be: they haven't explained to each other that their tastes and their likes in their intimate relationship have changed. most behavioral interventions, I think, work because you open up a channel of communication about sexuality and what you do. the issue is not so much whether his penis works or not, but it's whether he can share his feelings with himself and then with his partner

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Difference in levels of desire (between couple members) seen as common concern	9	26.5	Difference in desire, you know: what one therapist calls low sexual desire, I might call just a difference in desire between partners. The classic [problem] is: he wants more sex and she doesn't…I [also] see the reverse cases fairly often. If someone comes in and they're in a—this is particularly true in relationships where the couple comes in and she has a high desire, or he has a high desire, and the other person has low or no sexual desire, hypoactive sexual desire. And, often what happens is the continuum is so vastly different on one end versus the other that helping to look towards compromise is where the strategy comes in.
Interviewee emphasizes the value of accepting asynchronous sexual experience (different experience for both partners)	2	5.9	the thing that I'm writing about more now, and talking about more... is the idea of the value of both synchronous sexual experience—in other words, where both people are desirous, they're both aroused, they're both orgasmic, they feel really good and bonded as a couple—but also an acceptance of asynchronous sexual experiences, where the experience has a different role and meaning for one partner than the other, where it's better for one partner than the other, as long as it isn't at the expense of the partner or the relationship. there's a lot of skill-building around... being able to accept that the partner may not be in the same place you are. And not having that then become, you know, a pouty, blaming kind of thing.

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee indicates 'honeymoon' phase of high desire, evolving into less sexual phase, as typical relationship progression	3	8.8	[One cause of problems is] Ordinariness—how relationships get dull over time, and how that ordinariness has to be managed, and the habituation of sexual contact, when it's kind of got too routine and there's no energy connected to it for people.
Clinician uses a systemic psychotherapy/sex therapy orientation	5	14.7	The approach that I use...takes account of, psychodynamic and systemic dimensions—so systemic stuff, you know, about: we're all part of a social system, and those social systems are quite influential on our beliefs and attitudes. So, how we grew up as a family member, what our religion, our culture, our beliefs and value system says about what's ok and what's not ok in sex, and how that can be a mismatch between a couple in terms of their expectations, hopes, aspirations and desires for sex. the other main component...is systemic. And if you think systemically, then you are much more interested in the problematic processes that are going on now as a formulation, and...extending into wider extended family work kind of dynamics to understand the problem and how one might treat it.

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician uses a couple-based treatment approach (i.e. actively involving both couple members)	12	35.3	in my work the emphasis is seeing sex as a couple issue. Most often I see males now in couple therapy. We're treating the whole couple thing, rather than him as: he's got a plumbing problem we need to fix.
Clinician uses, or emphasizes use of, psychoeducation	19	55.9	I might be doing education work, I should say, as well...Just talking about how the body works, because people don't quite understand. So, maybe I might be showing some drawings, doing some educational work about what's happening, and then suggesting certain exercises we do quite a lot of psychoeducation. It's amazing, I'm sure you've come across it in your other interviews, just how ignorant a lot of people are. I say: "what you need to be able to do is learn-what are the signs in your body that tell you you're getting excited?" And again I'm going to the diagram, "before the [point of ejaculatory inevitability]".

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Couple relationship must be stable/ robust enough for sex therapy (i.e. potential for cooperation and communication)	9	26.5	I might use more relationship counselling techniques sometimes. But not specifically aimed at the sexual problem, but just aimed at improving the relationship so they can then tackle the sexual problem [through sex therapy]. with sex therapy, in that first session I'm assessing whether they're suitable for sex therapy, and the criteria that I would use would be: is the relationship good enough? one of the criteria for taking a couple into sex therapy is that they've got to have a robust enough general relationship to cope with going into sex therapy, because it is very diagnostic. If there are any cracks in the relationship, it will find them, and that's not conducive to a positive outcome of sex therapy if there is a shaky relationship In my early days as a therapist, once or twice in my enthusiasm I tried sex therapy with couples whose relationship was in a bad place. In both cases, the whole thing fell to bits fairly quickly
Clinician views behavioural interventions as more effective with client in a stable relationship (as opposed to single client, or client in an unstable relationship)	3	8.8	if there was a pattern of fairly sustained and aggressive argument I wouldn't consider them in the right place. And the rationale for that is: they need to be willing to work together in doing tasks. in this instance, for example, I would never use a behavioral approach because he was not in a stable relationship... I think a behavioral approach, outside of somebody who's actually already capable of reasonably engaging in a good relationship with a sexual partner who is willing, who is affectionate enough towards the individual to engage in some kind of couples work...It's a dodgy business.

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee frames couple/relationship counselling as distinct from sex therapy	8	23.5	which approach [sexual or relationship therapy] do you take first? Because I see them as very complimentary—it's relatively frequent that I will refer a couple to do some work with a relationship therapist first... with a view to them coming back to me [for sex therapy] when their communication skills or their negotiation skills or their conflict management skills are a bit more robust. if couples come and their presenting problem is, for example, that they have a sexual dysfunction and the rest of the relationship is being impacted because of the sexual dysfunction, we would tend to then refer them for psychosexual therapy. If their relationship is in a pretty poor state and as a result of that, not surprisingly, there are some sexual problems, then we would tend to think of it as being a couple therapy issue rather than a psychosexual issue.
Relationship therapy may be required before sex therapy	2	5.9	If the relationship is [not] good enough to have a collaborative alliance for the couple to deal with sexual problem…I would say then that actually what we're going to do is work on, first of all, the relationship. Because there's no point in going further on these behavioural things until we've done the relationship therapy.
Working with couple together has unique challenges (as opposed to working with individual)	1	2.9	in couples you can have two fairly high functioning individuals that, when you put them together, are functioning at a level that is much lower, because this is where the heat is, this is where the conflict is.

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes that couple counselling overlaps with sex therapy	7	20.6	sometimes the primary issue is a relational issue and not a sexual issue at all. Now you can use the sex as a metaphor, again, and work with that, and hope that it will—you can work with a couple's communication, you can work with issues of control and power and vulnerability in a sexual context, and it's going to have implications for the rest of the relationship. Sometimes you just put the sex aside and you work with just the relationship issues because that's what really needs the attention. a lot of people come in, they're not coming in as identified sex therapy patients. They're coming in with their spouse because they've got problems in their relationship, and then in course of working with them it turns out that they have some sexual problems.
Interviewee emphasizes importance of seeing both members of a couple during assessment	12	35.3	the first stage is that I will assess the couple; first of all, is there a sexual dysfunction?... Secondly, what's the state of the relationship? Are they ok to go straight into the sex therapy or do they need some counseling first? The next bit is done as individuals, which actually frees them up to say the things that perhaps they wouldn't say with a partner there...I then say to them: right, what I'm offering you is two hours of assessment each. So that's four hours, four individual hours. And I normally go sort of a-b-a-b, so I start with one partner, and then the other. The other thing that's important [is]: whenever possible to speak to the partner, or family members, because what it takes us 2-3 years to get at, a family member, or a close person who's allied with this client, can undo in five minutes.

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician sees couple members together and separately during assessment	9	26.5	In the original intake session they would be seen as a couple. It's possible that they would always be kept as a couple, it's possible that the ongoing psychosexual therapist might split them up and have an individual session with each of them, and then bring them back together. Usually I meet with a couple for one session together. And then I meet with each one individually, for an individual kind of assessment, just to give me a sense if there's anything going on that I need to be aware of. my way of working with couples is often to see the couple not just together, but individually as well. [The advantage is] I'm not in the dark about what is going on with the individuals.
Couple members may have secrets in relation to one another	5	14.7	What I find on a regular basis is that I'd say to the clients at the beginning: if there are any secrets, please make that clear to me. And I will hold secrets; I prefer not to, but I do. when I saw a couple I always saw them together first, and then asked to see each of them individually, and when they'd say "we don't have any secrets," my line was always, "well, it's not that we're going to find out secrets, it's that people relate differently on a one-to-one".
It may be possible for couple members to be more honest during individual meeting with therapist	4	11.8	working with the clients on their own is also really helpful because it gives them both a chance to say what they really like. in many cases the individual will feel freer to talk to me about his or her feelings and ideology without the partner present. They are able to say, "actually, now his snoring really irritates the hell out of me", you know, or "I don't like the way that she picks at her fingernails". Things like that come up.

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician works to identify divergent values between couple members, or conflicting beliefs about sex	2	5.9	I recently worked with a couple who had quite mismatched expectations of sex and very different understanding and experience of libido. And they had very different beliefs and experiences (from family backgrounds) about: what is a man, and what is a woman, and what are your roles?
Interviewee states that the individual within couple should take responsibility for personal sexuality	4	11.8	really the journey for people is a journey of: 1) healing, which means 'to become whole' and 2) what I'm now terming "sexual self-realization". Even if I'm working with a couple, the work is always about the individual in the couple relationship first...in fact what I promote is becoming selfish as a positive component of either self-love or masturbatory play, or couple dynamic. they want to please their partner, and it's often in that wishing to please their partner that they lose the ability to please themselves.
Interviewee stresses importance of relational intimacy for sexual functioning	7	20.6	Quite a lot of my work, right from the start, is about looking at different dimensions of intimacy in their relationship, and how important physical intimacy in all its glory is in the wider dimensions of their relationship. Because you know physical intimacy is only one of many types of intimacy.

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Reconnecting the couple, or building intimacy, stated as explicit overarching goal	4	11.8	Often, sex is the expression of intimacy in the relationship. Now sex can be many other things, but 99% of the time in a relationship that you're going to work on in therapy sex is one of the pathways to intimacy or vice-versa, so anything that builds intimacy should ultimately help in the sexual domain. Any defenses that you help them break down...that ultimately brings intimacy closer, should in theory help their sex life. often if they start to soften a bit on the edges there, and feel: "yeah, you know, I can listen to her, because she isn't going to go on all day" or "I can talk to him in a mild way, because I know he'll listen". They feel that they can start sort of looking at each other more and feel this sense of connection. And they can start to have sex spontaneously...so sometimes the quality of the relationship will really help.
Difference/tension between intimacy and eroticism	2	5.9	There are some people who really emphasize satisfaction, but not stability. There are people who emphasize stability but not sexuality. But when I think of healthy relationship—it integrates satisfaction, stability and sexuality. And I think if you're going to do that, you've got to integrate intimacy and eroticism.. I don't think intimacy and eroticism are adversarial. I think they can be complementary, but they're certainly different.
Fundamental challenge/aim: integrating intimacy and eroticism into the relationship	3	8.8	My mantra is: you've got to find the right degree of intimacy, the emphasis on non-demand pleasuring, and then finding erotic scenarios and techniques that add vitality, and unpredictability.

Table 5.7 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Feelings of ambivalence (about sex) are often present in couples	1	2.9	[Often] people are ambivalent about their sexuality, about sexual interest or expression… they recognize that something's missing and they want to do something about it, but on the other hand they're not quite sure what to do.
Sometwhing initially attractive about partner becomes frustrating in couple relationship	1	2.9	I will be looking at what the dynamics might be in their relationship. Particularly what projective identifications might be going on. Because often the situation is that a lot of what's attracted people at the beginning of their relationship has now become a source of frustration.
Interviewee emphasizes the damaging effects of ongoing rejection by one partner	1	2.9	rejection among couples is very, very difficult, it's very painful for people. One partner will constantly be trying to initiate, and will constantly be rejected, and that rejection then becomes quite damaging in the relationship.

Table 6.2

Diagnostic practices: number and percent of interviewees discussing themes/sub-themes explicitly and implicitly

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Interviewee expresses a critical view of (standardized) diagnostic model		10	29.4	2	5.9
	Diagnostic categories may be labelling/ stigmatizing for the client	6	17.6	2	5.9
	Diagnostic categories seen as describing symptom clusters	2	5.9	2	5.9
	Formal diagnostic categories limit treatment innovation	2	5.9	1	2.9
	Interviewee emphasizes that diagnostic categories are used as communication tools (i.e. when referring to medical professionals, or to help client conceptualize a sexual issue)	2	5.9	1	2.9
	Paperwork protocols dependent on work setting/context	8	23.5	0	0

Table 6.2 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Use of diagnostic categories dependent on workplace protocols	2	5.9	1	2.9
	Major financial interests (esp. drug companies & insurance companies) influence diagnostic systems or treatment practices	8	23.5	0	0
Sexual dysfunction/problem viewed as symptom of other psychological factors (i.e. other psychopathologies)		6	17.6	1	2.9
	Need (with some clients) to treat other psychopathologies before treating sexual problem	3	8.8	0	0
	Use of a surrogate partner (esp. to help with skills learning)	4	11.8	0	0
	Use of mindfulness	4	11.8	0	0
	Importance of (the client) being mentally/ emotionally present during sexual encounter/ activity	2	5.9	1	2.9

Table 6.2 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Treating sexual issue in life context (i.e. expanding focus beyond sexual issue)		7	20.6	0	0
	Importance of considering social context	7	20.6	2	5.9
	Clinician evaluates both negative and positive influences of social context	2	5.9	0	0
	Client's intersectional identity (i.e. interesection of different identity factors like gender/race/class/relig.) is seen as important to assessment and clinical work	1	2.9	0	0
	Interviewee sees gender socialization as an influential factor in sexual functioning	6	17.6	0	0
	Clinician considers client's social class as influencing sexual problem and/or treatment	5	14.7	0	0
	Clinician considers client's race/ethnicity as influencing sexual problem and/or treatment	1	2.9	2	5.9

Table 6.2 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Interviewee believes the cultural message that male arousal is autonomous/spontaneous affects sexuality	2	5.9	1	2.9

Table 6.3

Diagnostic practices: themes and sub-themes identified in research interviews, including representative/characteristic statements

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee expresses a critical view of (standardized) diagnostic model	12	35.3	the problem with the DSM is it's all based on the Masters and Johnson sexual response cycle…it's a very narrow approach. I don't really even like the DSM, now it's going to be 5, way of viewing it. Because it's like looking at the body as a plumbing system, or some kind of chemistry issue. DSM categories, a lot of them I don't think very useful. I think they're very heterosexually biased, and I think that things like, even the definition of premature ejaculation—it depends on who's judging. So, they're too subjective in the way that some of them are written.

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Diagnostic categories may be labelling/ stigmatizing for the client	8	23.5	Diagnosis creates the illusion that mental health is a thin band of experience, and tightly-reigned affective expression. So when I talk about my struggles with diagnosis as a point of departure—and this is why I focus on the intersectionality perspective so much—if I'm going to diagnose someone by a manual, then everyone I meet is fucked up. If everyone I meet is fucked up, then there's no hope. And then if there's no hope, I'm going to bring my despair into the relationship. That in turn, one way or another, gets translated to the person that they're really fucked up. to be 'impotent' in our society means…two things: to be without power, and to have no erections. We've linked them. There has been an effort by the medical community to get rid of the word 'impotence' and call it 'ED' treatment, but of course there's a bit of a fraud there, because if we look up things like the Viagra ads, it's quite a game they're playing. The guy, the ads on tv do not say that the guy has firmer erections, it just shows them happier, getting a corner office, bouncing a basketball. That is, he potent in all areas of life.

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Diagnostic categories seen as describing symptom clusters	4	11.8	my view on DSM-IV, V that's coming is: what it does with psychiatric, and all the conditions or the majority of the conditions, is actually cluster certain symptoms around normal distributions, rather than identify specific pathologies. They don't take enough account of the underpinning psychological factors…in [my model] we have much more comprehensive set of guidelines. it's a naming process for me, and it misses—some of the classifications miss people, because somebody may have hard enough penis for penetration, but may have no subjective arousal that goes with it, so is that a desire disorder, or is that erectile disorder? It's like—where do the things that cut across two aspects fit?
Formal diagnostic categories limit treatment innovation	3	8.8	[Diagnostic categories] can be both helpful and unhelpful, in that increasingly, within psychiatry I find that if people don't fit a category, but they have serious symptoms from a number of them, then people don't know quite what to do with them... It helps identify, but it also straight-jackets thinking and possible treatments. Where I think DSM categories are less helpful is where you get some of the more complex combined or dual diagnoses. For instance, the couple that I mentioned with completely mismatched libido—where is that in the DSM framework?...So, some help, but of limited help. And I don't think they take enough account of the underpinning psychological factors.

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes that diagnostic categories are used as communication tools (i.e. when referring to medical professionals, or to help client conceptualize a sexual issue)	3	8.8	I would still use the language of the DSM classification... And the reason why I do that is predominantly I'm communicating back to GPs. the issue of context is absolutely crucial to the question you have asked me, which is: how do I diagnose, in a way? The practical way I go about doing that, and what I've described, is a situation in which I have to find language to communicate… [a clinical case] has presented to me with premature ejaculation and erectile dysfunction. I have no doubt those two diagnoses are accurate. But as a depiction of what's going on with this person, it's not very helpful actually...it doesn't give the feel of what this person needs if he is to be helped.

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Paperwork protocols dependent on work setting/context	8	23.5	There's two questions here: first of all, how do you create a plan in your own mind for your own work? And then how do you provide a plan for the public system, or some system that requires you make a plan? Now, let's say the public system plan, the one you've got to provide to someone (might be a supervisor or someone), well, you have to jump through hoops...This is the bottom line...Now in my own work I don't do any of that. none of it. I find it very restrictive. A therapist has to be creative. They have to think laterally. They have to be able to stand back and see the whole world view. I would [use instruments/questionnaires], if I was working in an institution or setting where that was mandated I would. I have nothing against the using—in either setting, either psychodynamic or [behavioural]—using what is appropriate for purposes to demonstrate reasonable value. I actually used...when I was in a mental health setting, a questionnaire [for progress tracking]...A lot of times, if they, for lack of a better term, if [clients] liked you, they would say: everything was wonderful, perfect. And I finally felt that, putting it on paper, fine, it appeased my director at the institute, but I didn't think I got real information.
Use of diagnostic categories dependent on workplace protocols	3	8.8	I used to work as an NHS sex therapist…in the NHS they did definitely use those diagnostic [categories]

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Major financial interests (esp. drug companies & insurance companies) influence diagnostic systems or treatment practices	8	23.5	there's the whole social process, cultural process, by which things get defined as problems—and the controversy over female sexual disorder, whether it's actually if it's this, or whether it's the creation of pharmaceutical companies so they can sell products to us. So it's not straightforward as a system. you have to diagnose if you're going with insurance. there's other things that drive this diagnosis, drive, and I think that's financial, I think it's the medical care system in the United States and the world, that you get payment for a health problem if it's a disorder, not a problem. And so there's enormous pressure for people whose livelihoods depend upon getting paid if it's a disorder.
Sexual dysfunction/ problem viewed as symptom of other psychological factors (i.e. other psychopathologies)	7	20.6	if you hang out your shingle and you say you're a sex therapist, you're going to get a lot of referrals that present as a sexual problem, but really when you scratch are not going to be a sexual problem.

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Need (with some clients) to treat other psychopathologies before treating sexual problem	3	8.8	in some cases they cant tackle [sexual] problems unless they are less depressed or less anxious. There's some times as a couple that they actually need to have individual therapy before you can work on them as a couple. a person has to be what we deem to be coachable. That means they don't have a severe mental health condition, personality disorder, dysfunction. Because if they were, let's say, a very severe unmedicated schizophrenic, or severely clinically depressed, or severely anxious—so that they are really not functional, nor are they able to use cognition—they would not be what we call coachable. If they were an active alcoholic who shows up at a session drinking or drunk, they're not coachable.
Use of a surrogate partner (esp. to help with skills learning)	4	11.8	if one wants to learn a set of skills, let's say swimming, one could read about it, and one could watch what's going on, but unless you get in the water, the learning is not going to be as thorough or as immediate. And that's how I—that's the analogy I use, when presenting the possibility of surrogate therapy to any client. I've had experience working with surrogate partners, as the treating therapist in kind of a three-way model. And, honestly, the individual males who don't have partners, that's, in my opinion, the best treatment around, because many men don't really know how to connect to a real woman.

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Use of mindfulness	4	11.8	I don't teach them meditation because I don't see myself as a meditation teach[er]—but I direct them towards things like mindfulness. If they have an interest, and I don't care what it is, but anything that is an interest in expanded awareness, I kind of build on that. when I start to move from the cognitive into the body, into an awareness of the body, that's where gestalt methodology comes into play. And not just gestalt methodology, but also mindfulness practices, because in order to get into the body there needs to be a way of being more in touch with one's inner experience, moment-by-moment. articulating outcomes to patients about what they can expect, we again draw on the empirical literature, we talk about what mindfulness has been shown, study after study, to do.
Importance of (the client) being mentally/emotionally present during sexual encounter/activity	3	8.8	there's a lot of skill-building around: how can you be in the present moment? I do these touch exercises that everybody does—the sensate focus stuff—but I teach it as a way to first understand where the anxiety comes up, and then how to reduce it, and then how to simply be in present moment, and to be able to share deeply, both verbally as well as with touch, who you are in that moment. in sex: you're struggling, you know, to get an orgasm, you start getting anxious about "am I going to get an orgasm or not"—you are never going to get an orgasm. You know? But mindfulness—this idea of being present would be the counter to that. Practicing being where you are at the moment, you know?

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Treating sexual issue in life context (i.e. expanding focus beyond sexual issue)	7	20.6	someone might come in and say "I have an orgasm problem" or something, and I won't do the very narrow sexual counseling approach that people often do. I would take a much broader approach, and be looking at the whole person. We ask them to describe the problem in their own words, which is often very different to what the referrer told us. And things like: when did things change? Was it a gradual change or a sudden change? What was going on in their life at that time? And what, if any, action they've already taken to try to resolve it. We then ask them a few things about their general relationship and just general information about their sexual relationship, whether it's going on or not. We work energetically with those stories, with the whole story, not just the dysfunction part.

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Importance of considering social context	9	26.5	I feel the assessment needs to leave no stone unturned...I do a family history where they introduce me to all the members of their family, beginning with parents, and the siblings and themselves. From their perspective, not what other people say, but their perspective, as to who this person was or is, and their relationship to that person. And when we're done with that, then I do a sexological history, and... there are no questions asked. You're asking the client to: 'tell me about this, tell me about this. Which gives them more freedom to say whatever it is that they need to, or choose to, say. And we start out with them telling me about: what was the message about sexuality that they got from their family, from their church, from their school, from their friends, and any other sources? [Assessment asks about] everything. Where they're from, what their life was like growing up, what they do for a living, their jobs they've had in their life, that sort of stuff.

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician evaluates both negative and positive influences of social context	2	5.9	what made a difference was if there was another authority figure in their life that was more, for lack of a better term, loving and understanding, and made them feel that they were acceptable human beings. [Especially with non-self accepting gay clients the clinician aims] to look at the person in environment. Were there influences that were equally as important to that individual that were positive? So , were there community centers? Was there a gay teacher or counselor? A priest, a rabbi, an imam? Someone who was positive, or out as gay, that provided some counter-balance, if you will, to some of the messages that they got. That's also really important too, so the family of origin, as well as supportive others who may have countered some of the negative messages, even those that were unspoken.
Client's intersectional identity (i.e. interesection of different identity factors like gender/ race/class/relig.) is seen as important to assessment and clinical work	1	2.9	What I think is important for a clinician to be able to recognize... is that: sexual history is really important, and it's important to get that sexual history from a systemic and intersectionality perspective. So, issues of race, class, gender, religion, and also location—where did the client grow up?

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee sees gender socialization as an influential factor in sexual functioning	6	17.6	there's a whole lot of stuff around—particularly for men—the sort of socialization and learning and what people learn about sex and roles and gender roles, and things like that. So, men get very uptight sometimes about, particularly, things like erection problems. [For gay male clients]-what were the messages they got, not just about sexuality, male sexuality, but gay sexuality?
Clinician considers client's social class as influencing sexual problem and/or treatment	5	14.7	[Sexual identity issues] have to be looked at from the perspective of class, race and locale. As someone who, say, comes from a working class environment where options for gender variance, if you will: like a real man works, and a real man does this—is not necessarily going to be able to be in an environment, say an academic environment, where more people are being able to say: wait a second, question everything about what you think you know about your sexuality, your masculinity, your femininity. So, you have to look at class, race, gender, [and] religion.
Clinician considers client's race/ethnicity as influencing sexual problem and/or treatment	3	8.8	whatever the ethnic group is that I'm seeing—we often hear strains of influence on their thinking that help us realize that people import ideas from the culture into their sensibilities, and unless those are articulated, identified and articulated, they have an unseen influence on the person

Table 6.3 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee believes the cultural message that male arousal is autonomous/ spontaneous affects sexuality	3	8.8	he was having difficulty with erections...and she would say to him: "don't come near me unless you're sure you can have a good erection"...oh, by the way she was also a woman from a culture that didn't think that men needed to have any kind of sexual stimulation to get or keep an erection. So he would lie there thinking: "I have an erection, I want to have sex, I wonder if it's going to stay hard when I roll over to approach her?"

Table 6.4

Assessment practices: number and percent of interviewees discussing themes/sub-themes explicitly and implicitly

Themes	Sub-themes	Percent of interviews discussing theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Clinician conducts several sessions of assessment		4	11.8	0	0
Emphasizes importance of taking a thorough sexual history		11	32.4	1	2.9
Interviewee makes variable use of questionnaires		4	11.8	0	0
	Filling out questionnaire may serve a psychoeducational function for the client	1	2.9	0	0
	Clinician makes little use of questionnaires in sex or couple therapy	8	23.5	0	0
	Use of open-ended & broad questions to client in assessment	8	23.5	1	2.9
Use of predisposing-precipitating-perpetuating factors model		9	26.5	0	0

Table 6.4 (continued)

Themes	Sub-themes	Percent of interviews discussing theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Psychodynamic application of predisposing-precipitating-perpetuating factors model	3	8.8	1	2.9
Clinician views assessment as ongoing throughout treatment process		2	5.9	0	0
Attending to unconscious or other psychodynamic factors in assessment		10	29.4	2	5.9
	Attending to implicit factors in assessment	5	14.7	2	5.9
	Importance of informal assessment (inclusive of unconscious factors)	4	11.8	2	5.9

Table 6.5

Assessment practices: themes and sub-themes identified in research interviews, including representative/characteristic statements

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician conducts several sessions of assessment	4	11.8	one of the things I'll say to somebody is: listen, I generally take four sessions to assess you. To assess your situation. It also gives me an opportunity to see if I can work with you. It gives you an opportunity to see if you like working with me. one of the things I really talk a lot about and really care about is this idea of this four session assessment model: of seeing the couple together for the first session, seeing them each on their own to do a psychological, relational, sexual history, and then the couple feedback session.
Emphasizes importance of taking a thorough sexual history	12	35.3	you have to do a really good assessment…a sexual history that is not based on the old sort of [narrow] DSM model. the assessment may well last several sessions. It's not something that's rushed, it's not kind of a hundred questions. It's to actually understand their individual background, their individual sexual history and sexual experiences, particularly any abusive experiences either as a child or adult, individual medical histories and their history as a couple and the history of their sexual relationship as a couple , and then from that we'll be able to formulate and feedback to the couple how the therapist sees their problem and the way forward with it. So the therapist will think about the predisposing issues, the precipitating issues and the maintaining issues and will formulate this back to the client.

Table 6.5 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee makes variable use of questionnaires	4	11.8	I may use all sorts. It depends on the couple. I may use the GRIMS one or the CORE one…I don't always use them--in fact I don't use them very often. I do use questionnaires for a lot of things, but I'm not so sure about sex therapy, if I use questionnaires. I'm sure there are questionnaires. I mean, I just ask them questions, but I don't use a formal questionnaire typically. I... have used GAV-7 and PHG-9. I've used CORE quite a lot. But I also have very specific tools I might use as well. So I might use an OCD assessment tool. I might use quality of life assessment tool. I might use Asperger's assessment tool, particularly with fetish. It's not uncommon that you find, I'm finding, a lot of my clients with fetish also score very highly on the Asperger's scale. So I use a collection of assessment tools at different times, I suppose. But I don't have to use any. I'm not obliged, unless I'm working for certain agencies that have a requirement, then I tend not to use anything all the time if that makes sense.
Filling out questionnaire may serve a psychoeducational function for the client	1	2.9	it's not just about what it gives you as a therapist, but actually by filling them in it can focus the client on it.

Table 6.5 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician makes little use of questionnaires in sex or couple therapy	8	23.5	I don't use many questionnaires, or history-taking things at all—so I don't really have a terribly detailed past history on most of my patients. If I see them alone I probably have gotten more information, but if I see them as a couple I may not have. And so it's the current problem, the history of the current problem: when, where, how, when it's better, when it's worse...that matters to me at first. I check-in a lot about our goals. I can't say I keep a metric. Not with couples therapy. I might ask about depressive symptomatology and anxiety and things like that in those assessment phase. But unless it comes up again, or unless I find something that's really problematic in the beginning I don't usually measure our goals
Use of open-ended & broad questions to client in assessment	9	26.5	I would ask an open-ended question, I would say: "how can I help you?" Well, after trying to make them comfortable: "did you have difficulty finding the room" "isn't parking impossible around here?" That sort of thing. I would probably say: "Ok, so why don't you take turns telling me what brings you in?" So it's open-ended. And it's always interesting to see who speaks first and who speaks second. Whether they let each other speak. And then to immediately establish the back-and-forth.

Table 6.5 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Use of predisposing-precipitating-perpetuating factors model	9	26.5	the therapist will think about the predisposing issues, the precipitating issues and the maintaining issues and will formulate this back to the client. I would talk about predisposing causes to a sexual problem, precipitating causes, and then maintaining causes. I get people to start really broad, and say: you've got to look at all the different kinds of things, causes, and you can divide them up into those three categories. I do always write a formulation. Always. And...I do categorize that as the predisposing, precipitating and maintaining factors, because I think that helps me have a better discussion with the couple.
Psychodynamic application of predisposing-precipitating-perpetuating factors model	4	11.8	I would involve them in jointly looking at the predisposing, precipitant, and maintenance factors, you know: what's keeping this going for you? What's your interest in still maintaining this symptom?
Clinician views assessment as ongoing throughout treatment process	2	5.9	If they continue to see me, and make more than 1 or 2 appointments, I'll always ask them: "so what has changed since the last time you saw me?" So I'll gauge from that whether they're getting it, or whether it's hopeless, or they're going to need a little bit more hand-holding.

Table 6.5 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Attending to unconscious or other psychodynamic factors in assessment	12	35.3	people tend to have things locked up inside of our minds that we don't want to look at because we're afraid of that material, or we're concerned about it…and so a way…to gain control, make decisions about these things, is to open up, essentially to open up this closet in their mind, and let the light in and see what's there. And when they see what's there, then they can decide, they can see how big it is, and they can decide what they want to do with it. it was like an anger turning on himself. He was angry at the world, that also made him also feel bad. To understand that depth of meaning, that's what you learn in some of these psychodynamic therapies. a lot of what's going on from a psychodynamic point of view is...I'm trying to pick up what's going on beneath the surface, looking at: what sort of patterns of connection between the past and present there might be, what sort of transferences, whether this person is coming expecting me to solve everything, or whether they've been places before and therefore they've very skeptical about anybody helping. How much they might see me as an authority figure. And also I will be looking at what the dynamics might be in their relationship.

Table 6.5 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Attending to implicit factors in assessment	7	20.6	one of the things I do with students in the psychodynamic input, is to get them to be aware of the non-verbal information that's coming during an assessment that can be looked at psychodynamically. I want to be looking at how they're breating, how they're talking, where they go. assessment is not just giving a questionnaire or asking a bunch of questions. It's really trying to get a whole picture, feeling of the person. Noticing what they do with your questions, and then if you see them have a reaction, tracking that down and seeing where that leads
Importance of informal assessment (inclusive of unconscious factors)	6	17.6	I literally—and this was something from my psych training—I would write down the very first words they said when they walked into my office, even if it was something like: "wow, that's a pretty plant". I mean, as crazy as that sounds, 99% of the time their very first comment had a lot to do with what we were going to be doing. Something as off the wall as "wow, that's a nice plant" or something like that. you would be surprised to find out how much you can just see by the way that the person organizes his/her email, the syntax, the diction, if they're using all caps, or they're using no caps. Or sometimes even from their email address.

Table 7.1

Goal setting methodology: number and percent of interviewees discussing themes/sub-themes explicitly and implicitly

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Clinician views goal setting as a client-led process		12	35.3	2	5.9
	Client seen as the expert on the sexual problem	2	5.9	0	0
	Success is defined by the client (subjectively)	6	17.6	3	8.8
Interviewee expresses critical view of performance-based sexual model		9	26.5	2	5.9
	Interviewee sees performance demand as a causal factor in sexual dysfunction	10	29.4	1	2.9
	Common tendency for people to be orgasm-focused (contributing factor in sexual problems)	3	8.8	1	2.9
	Interviewee stresses importance of viewing sex as more than just intercourse/ penetration	2	5.9	0	0

Table 7.1 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Interviewee differentiates between arousal and desire	1	2.9	1	2.9
	Interviewee places emphasis on pleasure (de-emphasis on performance)	4	11.8	1	2.9
	Desire/pleasure/satisfaction emphasized over arousal/orgasm/performance	5	14.7	4	11.8
Goal-setting viewed as a collaborative process/negotiation between client and therapist		12	35.3	3	8.8
	Interviewee emphasizes importance of realistic therapy goals (therapist role in ensuring)	10	29.4	2	5.9
	It is common for clients to begin with unrealistic goals	5	14.7	2	5.9
	Interviewee emphasizes focus on acceptance (especially as prior to focusing on change)	3	8.8	1	2.9

Table 7.1 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Goal-setting combines subjective goals with fundamental/universal health principles	2	5.9	0	0
	Overarching aim: helping the client to formulate and work towards a vision of sexual health	2	5.9	0	0
	Need for a clearly defined/definable problem to work on in ST	1	2.9	0	0
	Clinician stresses setting specific goals/ areas for work	9	26.5	0	0
Clinician holds beneficent values/goals in relation to client & outcome		7	20.6	4	11.8
Clinician attempts to involve both partners in client-led goal-setting process		5	14.7	1	2.9
	Usefulness of subjective, client/couple-specific goals (rather than number of orgasms, etc.)	4	11.8	3	8.8

Table 7.1 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Partners may have different goals	4	11.8	2	5.9
	Problem understood according to client's subjective frame of reference	1	2.9	2	5.9
Use of shifting formulation		2	5.9	3	8.8
Clinician tracks progress of the work		3	8.8	1	2.9
	Goals often change/evolve through therapy process	6	17.6	1	2.9
	Need for effective progress tracking tool/ system	1	2.9	1	2.9
	Limitations of quantifying progress	1	2.9	0	0
	Use of subjective estimate (i.e. "scale of 1-10") rating scales	2	5.9	0	0
	Need to focus on both positive and negative aspects of therapy progress	2	5.9	0	0

Table 7.1 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Overarching aim: for sex to play a positive role in relationship	2	5.9	0	0
	Interviewee emphasizes relational intimacy (i.e. between client/patient and partner) as an overriding treatment objective	2	5.9	1	2.9
Interviewee sees monogamy as opposed to biology		2	5.9	0	0

Table 7.2

Goal setting: themes and sub-themes identified in research interviews, including representative/characteristic statements

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician views goal setting as a client-led process	14	41.2	Treatment goals [are] something we would discuss after those sessions of assessment, so we get a sense: well, ok, what are our goals for these sessions? And I try to use the word "we", like "what are our goals?" I try not to impose goals. Usually the client identifies the objective. I always let the couple set the agenda. It's their life, it's their relationship, and I'm there to help them achieve that.
Client seen as the expert on the sexual problem	2	5.9	the client essentially is the boss. The therapist is sort of the employee, and it's a discipline that gives the power, the ultimate power, to the client himself or herself. And it's a matter of looking at: what is the issue that they're bringing up now?...And then using the various modalities that I use, to go back, for them to understand where this comes from. Then, by knowing that, then knowing: where do you want this to go?
Success is defined by the client (subjectively)	9	26.5	what I always tell my couples is: there are no 'shoulds', there are no rules here... whatever it is you do, that's fine, as long as the two of you are happy. whatever their goal was—if they tell me they have made some specific inroad like that, I feel that that's a success. Does it solve all their problems? Not by a long shot. But if they came to me because they were not getting along and now they're getting along, or they were non-orgasmic and now they are at least occasionally orgasmic, that to me is success.

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee expresses critical view of performance-based sexual model	11	32.4	culture constructs our reality of our bodies, so we get taught that we should be able to fuck all night like rabbits. With men, performance anxiety is probably the most central part. I mean, they may have some physiological stuff going on, but it's more than anything performance anxiety. the more he ramps up, the more anxiety he ends up having: why isn't it working?...then when he does try, things don't work because he's already got so much performance anxiety.
Interviewee sees performance demand as a causal factor in sexual dysfunction	11	32.4	I was seeing a couple where the guy had low desire, and his wife was very frustrated, and he said to me, after several sessions: "you know, when I have desire, and think about approaching my wife, I then think that—as soon as she wants to have sex, I feel it as a demand. And it blocks me. Or if she wants to have sex, I feel it as a demand and it blocks me." There are verbal analogies…"there's always another bus around the corner". Meaning, if you just forget about it for a while, do something else, another bus will come, another erection will come, and if you don't worry about it, don't try to make it happen, it'll happen. oftentimes we can feel the pressure that young men have to perform intercourse. Not just in performing it, but in being what we call a 'stud', lasting a very long time in the vagina. And so, there's an insecurity that comes from the individual culture of the person.

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Common tendency for people to be orgasm-focused (contributing factor in sexual problems)	4	11.8	They become so genitally-focused, or orgasm-focused, that they actually sort of have lost sight all the other wonderful sensations and arousal that the body can actually allow them to have. not even being able to allow themselves to say that this is a pleasurable activity, starts to feed into why they lose the erection...as if it's an event-focused process.
Interviewee stresses importance of viewing sex as more than just intercourse/ penetration	2	5.9	[Conventional clinical goals] are really located in a certain ideology of sex and what it should involve. Which is often part of the problem. You know? So you want to say, "actually, is it so important that you're erect? Is it so vital that you have an orgasm?" And that's where I would depart from the more conventional sex therapy, which takes that as a given, that people need: erection, penetration, orgasm, and that's what sex should involve.
Interviewee differentiates between arousal and desire	2	5.9	I basically talk about desire as something that is much more than an erection…men say: "I desire my wife, I really do. I just can't get the mechanism to work". And that sort of gives you an example where we can't just say it's the same as: if I desire, then I have an erection.
Interviewee places emphasis on pleasure (de-emphasis on performance)	5	14.7	what I mean by 'pleasure' is not orgasm...It's the overall experience, and the good outcome definition is that the couple feel good about themselves and each other, and some kind of pleasurable touch experience encounter has occurred, with no particular outcome required.

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Desire/pleasure/ satisfaction emphasized over arousal/orgasm/ performance	9	26.5	we're there to make sex pleasurable and enjoyable for both of you. To give them a good experience of being together sexually would be an objective. Timings and [quantitative/performance-based criteria] wouldn't really be on the agenda. I encourage people to recognize that orgasm does not have to be the end of sexual contact, but the beginning of a new level of sexual contact
Goal-setting viewed as a collaborative process/ negotiation between client and therapist	15	44.1	I like to suggest goals, but I always tell them, "this is your homework. This is something you guys gotta think about. What do you want to work on? What is the thing that needs to change? Let's come up with a list. Let's come up with idea"... Because I find it doesn't work well when the therapist says, "well I think you need to work on this only"...[it's] largely client-directed, with a few [therapist] suggestions. you're going to ask the couple what it is that they want. Now, if that's realistic, and if the therapist thinks it's a realistic objective, fine. If it's not, then there's work to be done before everybody can agree on what an objective is. And of course the couple may have different objectives as well. I do find out what they want, where they feel they want to be. So it's based a lot on what's coming from them...I will negotiate on what they're saying. I have a lot of people say they just want to be happy. But I'm not going to take that...So it's based on realistic goals, and also from their perspective.

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes importance of realistic therapy goals (therapist role in ensuring)	12	35.3	So, we're looking at predisposing, precipitating, and maintaining factors. But before we do that, we make sure we've identified exactly what the problem is, so there's no mix up about that. And then we agree what the couple's goals are. And it's quite important, then, to make sure that those are realistic goals and as likely to be achieved as can be predicted. They set the goals and I tell them whether the goals are achievable. I would ask them what the issue is, or what the problem is, and ask them what they want, instead. And we would move between those two things. And the way that I typically do it is by concretizing abstract concepts.
It is common for clients to begin with unrealistic goals	7	20.6	Sometimes, though, their objectives may be unreasonable. You know, not unreasonable, but may have to be tempered by the reality. [The internet/media] sets up false expectations for couples…it's good for people to be educated and participate in their care, but [people] kind of have the attitude that everything can be fixed. Like: you have a problem, you go see the doctor, your therapist, and you're fixed. And I'm a big believer that, no, it's a process, and you learn to cope with some things, and some things can't be fixed, and sometimes you change emphasis, and a lot of sexual difficulties are really not problems to be fixed, they're problems to be worked around.

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes focus on acceptance (especially as prior to focusing on change)	4	11.8	This idea of starting with acceptance and then talking about change is crucial. there's always our managing to live with our disability, which is not the same thing as changing their disability. With that person, I'm wanting amongst other things to offer them hope.
Goal-setting combines subjective goals with fundamental/universal health principles	2	5.9	[Setting objectives is] individual, but it also straddles the line between being individual and also having to be based on some basic fundamentals of sexual health for everyone.
Overarching aim: helping the client to formulate and work towards a vision of sexual health	2	5.9	ironically, a lot of the times when you ask people what do they hope to gain, they don't know what to say. They're just telling you that they're in some distress, or some discomfort, and they want you to fix it. And so, it was a collaborative process to find out, really, what they hoped to gain out of therapy. the therapy is to move them towards their vision of sexual health...many times the men have never really sat down and thought about: ok, what's my vision of sexual health? Who do I want to be? If I were to think of my sexual life as being really content, meaningful, everything I want it to be, or at least satisfactory, what would that look like? And then the therapy is about how to help you move towards that vision of sexual health.

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Need for a clearly defined/definable problem to work on in ST	1	2.9	there has to be a definable, if you like, *DSM-IV* dysfunction that we can work with.
Clinician stresses setting specific goals/ areas for work	9	26.5	I hope you'll pick up from that: those are pretty specific goals. It's possible to go back and say: "is that true?" I would have gathered in their individual meetings each of their goals, which are very, for me, always I formulate as objective SMART goals. So: specific, measurable, achievable, realistic, and time-limited. I would present their goals and then I would present my synthesis of that.
Clinician holds beneficent values/goals in relation to client & outcome	11	32.4	what I try to do, is try to enhance the quality of life for the clients that I see. I'm wanting amongst other things to offer them hope. And again, foreground the Gestalt notion of helping them. This is about philosophy, isn't it? How do I see my role? And I see my role as being: someone who makes myself available to other people, to listen them, to be alongside them, to be a witness to their experience of what life is about. Perhaps to share, if I have a therapeutic alliance with them, what I believe, for me, to be the meaning of life.

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician attempts to involve both partners in client-led goal-setting process	6	17.6	I will discuss [clinical goals] with the couple, because they have to decide where they want to put their time, where they want to put their effort. I ask them to write out: what three things could your partner do to make the relationship better—what specific three things? What specific three things could YOU do to make the relationship better? What three things, specifically, could your partner do to make your sexual life better? And what three things specifically could you do to make your sexual life better?
Usefulness of subjective, client/ couple-specific goals (rather than number of orgasms, etc.)	7	20.6	the most important thing in terms of treatment goals is that it isn't a rigid thing, like number of intercourses, or number of orgasms. It is much more this notion that we've found a couple sexual style that really fits us. in the 70s, they actually had these outcomes like: you should be having sex 3 times a week, or erections would be occurring in certain ways, or they could last more than two minutes....that's crap. That will create performance anxiety if there wasn't any to begin with...I tell couples: look, I'm not going to play the numbers game with you. We're talking about quality of experience.

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Partners may have different goals	6	17.6	Setting goals was always a collaborative process to get both the man and the woman to say what they hoped to gain. When the problems come in is when there is an incompatibility [of goals/aims] between the two partners. I've had recently a problem where the woman has not wanted sex at all. Because she doesn't feel the relationship is loving enough...the woman feels: "I don't want sex until we have a good enough relationship." And he says: "actually, if we have sex then I feel warmer and softer". And so it's a bit of a vicious cycle. She says "I want you to be warm and soft before we have sex" and he says "that does soften me, and warm me". So it's a real vicious cycle.
Problem understood according to client's subjective frame of reference	3	8.8	I think the basis of most problems are: the way one frames the situation to oneself.

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Use of shifting formulation	5	14.7	people often find that actually the goals that they have at the beginning do shift over the process, and the outcome of this might be: yes, you know, you find a way to start having these erections that you want, fine. But it might be more that you begin to see: actually there's other things I can do without an erection. Or it might be something in the middle. So, I think I'd be a bit cautious about a very fixed therapeutic goal. if they feel that's the problem that needs to get solved, then yeah that's one problem, and then some other problem may come up too. That goal-setting is what, always, we come back to. Now, by the way, that can morph and change.
Clinician tracks progress of the work	4	11.8	I would also contract, when setting goals, that we will review them. So that: this is what you started asking for, and ok I'll agree to do that, let's spend [time reviewing]. the client's stated objective and goal is always worked into the therapy, and you're always checking with them...: how are WE? How's this relationship? Are you getting from this what you need? you're constantly working with the objective... you're always bringing it into the room to make it conscious.

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Goals often change/ evolve through therapy process	7	20.6	if I feel we're on the wrong track, or not attending to certain things, I may review what we're doing, and ask if they want to maybe shift in a different direction because of how things are working out. So, it's really a matter of assessing what's the most pressing at the moment, and starting with that, and then shifting gears if we need to. I might not even encourage them to look towards their ideal goals right at the beginning. I might take a step on the way and perhaps suggest that we focus on the sensual, sensate-focus work as the primary goal, and then see how that goes and where that takes them. Giving the impression if you like, giving the very clear message, that it's always in their control to say: well this is good enough for us, you know, we've got as far as we want to go for the moment.
Need for effective progress tracking tool/ system	2	5.9	there is [a concern] about alot of therapists not having any idea about whether what they're doing is actually having a positive impact on clients, and you know, I'm also kind of skeptical of people who wouldn't evaluate what they are doing at all
Limitations of quantifying progress	1	2.9	the most important variable is this acceptance and satisfaction, rather than specific behavioural numbers

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Use of subjective estimate (i.e. “scale of 1-10”) rating scales	2	5.9	I have exercises where we work together, and I say "list several things that are working about your relationship, several things that are not working. Give yourself a score, give your partner a score". A lot of [progress tracking] is a lot more personable...I would ask clients for their own scaling. You know...: scale of 1-10, one being the worst, how you feel today, and what would you do to improve that?
Need to focus on both positive and negative aspects of therapy progress	2	5.9	It’s about establishing a feedback climate which is not about bringing back a report to teacher, or getting a mark out of ten, or giving me their best sort of spin on it. It’s about, really: what went well? What didn’t go so well? What do they view the problems as being? And what do they think needs to shift to help it go better next time? talking about change is crucial...starting off with what works and then talking about what is dysfunctional and what they’re trying to grow.
Overarching aim: for sex to play a positive role in relationship	2	5.9	here's my mantra: intimacy, touching and sexuality--you want it to play a positive, integral role in your relationship. That's the overriding goal.

Table 7.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes relational intimacy (i.e. between client/patient and partner) as an overriding treatment objective	3	8.8	if a couple decides they've never done it before but they're going to a sex shop, and look up strap-ons, then they're sharing something. If they walk out of the store, they say "that isn't for us," they're still closer as a couple for having done that. So, I try to think as broadly as I can about it, but I don't rule out sex, and I don't put it into separate categories. I put it as a bridge to intimacy.
Interviewee sees monogamy as opposed to biology	2	5.9	There's another dimension, which is sexual boredom or ennui. And that's one of the huge components: we're not wired biologically to stick it out with a partner. I just look at evolution, and I explain to them why evolution makes it so that in long-term relationships testosterone levels go down on both sides...so we're almost primed not to want someone after a few years anyways....The fact that we stay together is an artificial construct, and it's part of our cultural sexual scripting. But now we do. And now we have to fool mother nature

Table 7.3

Critical sex therapy and working with diversity: number and percent of interviewees discussing themes/sub-themes explicitly and implicitly

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Interviewee sees knowledge/ understanding of diversity as an important skill		3	8.8	0	0
	Therapy field seen as ill-equipped to deal with diverse (i.e. LGBT) clients	3	8.8	1	2.9
	Interviewee emphasizes that a heteronormative model of sexual behaviour may be common in mainstream sex therapy and/or sexual medicine	5	14.7	1	2.9
	Need for more/better training (for sex therapists) in sexual diversity	3	8.8	0	0
Interviewee emphasizes possible need to affirm identities outside the norm		1	2.9	1	2.9
	Influence of internalized homophobia on client emphasized as important to treatment	2	5.9	0	0

Table 7.3 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Interviewee emphasizes reflective stance (therapist's use of)	2	5.9	0	0
	Permission-giving as a clinical technique	5	14.7	0	0
	Use of a non-pathologizing or sexual health model	7	20.6	1	2.9
	Use of a dimensional (rather than categorical) model of sexual health/problems	1	2.9	1	2.9
	Emphasis on personal authenticity	2	5.9	2	5.9
	Clinician lets the client lead the therapy process	2	5.9	0	0
Use of normalizing the client's concern or identity (as a clinical technique)		12	35.3	1	2.9
Interviewee uses social constructionism to conceptualize client cases		1	2.9	2	5.9

Table 7.3 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Interviewee emphasizes fluidity/variability (and attention to fluidity) of client's identity and sexuality	3	8.8	0	0
	Narrow definition of "sex" seen as prevalent in society (and as internalized by client)	2	5.9	1	2.9
	Heteronormative model of sex seen as prevalent in society (affecting clients)	2	5.9	0	0
	"Sexual imperative" (assumption that everyone wants sex) seen as prevalent in society	2	5.9	0	0

Table 7.4

Critical sex therapy and working with diversity: themes and sub-themes identified in research interviews, including representative/characteristic statements

Themes/sub-themes	Interviewees discussing themes/sub-themes		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee sees knowledge/ understanding of diversity as an important skill	3	8.8	there's one sort of line whereby we regard LGBT, asexual, bdsm, non-monogamous, all of sort of what is seen as minority sexuality or gender. But it's not actually minority in all cases, some of it's majority. But, anyway, the marginalized ones, we can train people specifically in each of those things... So people have an awareness—they can get a lot more knowledge of specific identities and specific practices.
Therapy field seen as ill-equipped to deal with diverse (i.e. LGBT) clients	4	11.8	[A lot of psychologists are] going to take their heteronormative bias, and they're going to say: "oh, ok, all gay men just want to stick it in the anus, because there's no vagina". I'll bet you there are a lot of psychologists who don't even know that there's such a thing as anal-receptive and anal-active. "What would THAT mean?" they'd say.

Table 7.4 (continued)

Themes/sub-themes	Interviewees discussing themes/sub-themes		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes that a heteronormative model of sexual behaviour may be common in mainstream sex therapy and/or sexual medicine	6	17.6	a lot of what is pathologized by the mental health community, specifically in the DSM and its diagnostic categories, and in the languaging and the posturing and the judging of many mental health practitioners, who actually work with some of the same people I work with, fail them in their lack of sensitivity, and even training, around sexuality. [Clinician recommends] systemic approaches, and some of the systemic ways of questioning—Socratic questioning and circular and interventive interviewing techniques—they're fabulously non-directive, but also very probing in a very respectful way. And I think the systemic notions of neutrality and curiosity, those key principles, are really good principles for looking at the sort of diversity of human sexual behavior. one book I read ... was like: "all of the examples in the book are going to be heterosexual people, because that's statistically the norm, so, people in same-sex relationships will have to think about how it applies to them". I was just like ahhhhhh?
Need for more/better training (for sex therapists) in sexual diversity	3	8.8	I also think if you were to poll, let's say, the AASECT certified sex therapists... what you'd find is that very, very, very few of them are gay-identified, and... few as well, have the background, the training, the sensitization, the language, the understanding, and the ok-ness with being able to ask the right questions.

Table 7.4 (continued)

Themes/sub-themes	Interviewees discussing themes/sub-themes		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes possible need to affirm identities outside the norm	2	5.9	we have to be aware of the world we live in, so that's where something like Darren Langdridge's gay-affirmative therapy is [useful]. You might have to work a bit at affirming, say, identities that are outside the norm, the normative, because the person has so much experience of having those disaffirmed, that you know, maybe you put your therapeutic weight around saying: "actually yes, kink is ok, non-monogamy is ok. Yes it's alright to be gay."
Influence of internalized homophobia on client emphasized as important to treatment	2	5.9	a lot of...the work that I'm seeing and doing has been related to trauma histories, and internalized homophobia. We spent quite a lot of time talking about [this client's] sense of, really, disapproval, and his own very deep prejudice about homosexuals. So he was one of these gay people that—[while] he was quite keen on gay rights, and ostensibly was very active in protesting equality of sexual orientation...—actually he had terrible prejudices about it, and felt that gays were lesser.
Interviewee emphasizes reflective stance (therapist's use of)	2	5.9	when people say 'open and supportive' I often say to myself: 'what the fuck does that mean? What are you talking about? So, when I supervise folks and they say "I want to be open and supportive" one of the things that comes up for me is you know, that position of being open and supportive is a potential iatrogenic injury to your client, if they don't understand what you mean, or you can't define what that means.

Table 7.4 (continued)

Themes/sub-themes	Interviewees discussing themes/sub-themes		Representative/Characteristic Statements
	Number	Percent (%)	
Permission-giving as a clinical technique	5	14.7	a lot of what we all do is permission-giving and normalizing. every session, re-permission them, we begin with permission. And there's an implicit permission given just in having them being ok about asking for help around sex. the fact that I'm going to demonstrate the language is itself permissive because it allows them to respond in a like manner. Sometimes I will frame a question which, as it were, subsumes another question along the way. Like I might say about masturbation: I don't say 'do you masturbate,' I say 'when you masturbate, do you find that…'
Use of a non-pathologizing or sexual health model	8	23.5	I try not to pathologize any more than I have to. You know, sometimes a person will call me up and say: "my wife is experiencing sexual aversion," and I try to discourage them from labeling it. I don't like the word 'dysfunction,' you know? It's all part of the DSM. I usually talk about sexual 'problems', or sexual 'difficulties', or sexual 'issues'
Use of a dimensional (rather than categorical) model of sexual health/problems	2	5.9	I see it as on the continuum of worry-problem-and-disorder, as see it as, on the continuum, a sexual problem, not a sexual disorder or dysfunction, or a psychiatric diagnosis.
Emphasis on personal authenticity	4	11.8	[My work focuses on] helping people become who they truly are. In other words, claiming the authenticity of their sexual being.

Table 7.4 (continued)

Themes/sub-themes	Interviewees discussing themes/sub-themes		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician lets the client lead the therapy process	2	5.9	I'm often quite led by the client...there's quite a trust the client has a pretty good idea what the important things to bring are. I would offer the opportunity to see whether they wanted [to discuss the therapy relationship] or not. I think it's really important to give control, if you like, of the direction, to the client at all times.
Use of normalizing the client's concern or identity (as a clinical technique)	13	38.2	Whatever they're dealing with, basically what you say is: "you know what? What you're feeling right now is perfectly normal. Across orientations, across modalities, normalizing is a terrifically important part of what a psychotherapist does. So, measuring outcomes, and measuring progress powerfully interfaces with normalization—that the expectations the people have about their lives change—and something that initially would have seemed to them utterly unsatisfactory as an outcome becomes, actually, a very good outcome. He's telling me "I'm a monster, I shouldn't have been born". And I'm telling him: "actually, that's not [true]. Well, I don't see transgender in that way, I don't think there's anything wrong with being transgender, and transgender people exist in all times and all cultures, and they're perfectly ok people".

Table 7.4 (continued)

Themes/sub-themes	Interviewees discussing themes/sub-themes		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee uses social constructionism to conceptualize client cases	3	8.8	increasing the possibilities for somebody is really part of therapy. And loosening what is sedimented. And enabling them to see things a bit differently...In a way, therapy has a lot in common with, say, queer theory, or sort of certain branches of social constructionism, which are about kind of loosening up and trying to see multiple alternatives rather than just one fixed route.
Interviewee emphasizes fluidity/variability (and attention to fluidity) of client's identity and sexuality	3	8.8	The reality is that sex by its nature tends to be variable, flexible, and have different roles and different meanings for people. [One] way to go is the more queer kind of approach...not necessarily expecting them to be the same from session to session, and seeing sexuality as something much more fluid and changing and much more integrated with the rest of their life. And not really thinking: how do I work with a lesbian client? How do I work with a transgender client?
Narrow definition of "sex" seen as prevalent in society (and as internalized by client)	3	8.8	To me, the problem with the word 'sex'...is that it's been so limited in its definition that I don't even LIKE the word anymore. But when you talk about somebody seeking something, what the pleasure model, what I would like to see happen is that they actually seek connection. And that's a whole different ball game. That's not sticking-it-in and getting off, you know.
Heteronormative model of sex seen as prevalent in society (affecting clients)	2	5.9	the entire world is still heterosexist and heteronormative, including [psychology] professionals.

Table 7.4 (continued)

Themes/sub-themes	Interviewees discussing themes/sub-themes		Representative/Characteristic Statements
	Number	Percent (%)	
"Sexual imperative" (assumption that everyone wants sex) seen as prevalent in society	2	5.9	a lot of the information out there makes people feel abnormal if they don't want to have sex, you know, five times a week.

Table 8.1

Aetiological factors: number and percent of interviewees discussing themes/sub-themes explicitly and implicitly

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Interviewee emphasizes that aetiology is multi-factorial		5	14.7	2	5.9
	Outside life factors (professional, personal, etc.) contribute to sexual problem	3	8.8	1	2.9
	Causal factors seen as overlapping	1	2.9	1	2.9
Clinician emphasizes client's early life (as affecting current relationships and sexual functioning)		24	70.6	0	0
	Clinician focuses on client's family of origin in assessment and treatment	20	58.8	2	5.9
	Clinician uses a developmental focus	5	14.7	1	2.9
	Therapy focuses on influence of early life parental relationship over current sexuality	10	29.4	0	0

Table 8.1 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Therapy focuses on client's attachment relationships/attachment style		10	29.4	5	14.7
	Focus on client's relationship schemas, models or scripts	6	17.6	6	17.6
	Interviewee emphasizes the significance of past trauma (and its possible influence on current sexual problem)	15	44.1	2	5.9
Interviewee emphasizes religious background's potential influence on sex/ sexual functioning		13	38.2	1	2.9
	Emphasis on spiritual aspect of sexuality	4	11.8	0	0
	Interviewee emphasizes possible benefits of involving a religious/spiritual leader in therapy	3	8.8	0	0
Interviewee sees depression as causal/ contributing/underlying factor		9	26.5	0	0

Table 8.1 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Lack of privacy as a contributor to sexual problems		2	5.9	0	0
Knowledge/skills (i.e. psychosexual skills) deficits as contributing factors in sexual problems		12	35.3	1	2.9
Interviewee sees anxiety as causal/ contributing factor		16	47.1	1	2.9
Interviewee sees guilt as an etiological/ influential factor in sexual problems		6	17.6	1	2.9
Interviewee sees shame as an etiological/ influential factor in sexual problems		7	20.6	2	5.9
	Interviewee believes that, for clients, discomfort (i.e. shame or sense of stigma) discussing sex is common and affects treatment	4	11.8	2	5.9
	Interviewee stresses the benefit of client disclosure (to prospective partner)	1	2.9	0	0

Table 8.1 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Disclosure of sexual problem (to therapist) may occur later in therapy	1	2.9	1	2.9
	Importance of the therapist initiating discussion of sexual aspects	4	11.8	0	0
Importance of therapist being comfortable/competent to discuss sex/ sexuality		2	5.9	2	5.9
Clinician emphasizes cultural factors' influence on sex/sexual functioning		14	41.2	3	8.8
	Clinician considers the influence of sexually restrictive cultural factors	8	23.5	0	0
	Sex-negative messages seen as prevalent in Western culture	4	11.8	0	0
	Sexual difference/non-conformity equated with pathology in Western culture	4	11.8	1	2.9

Table 8.1 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Sexual media (esp. pornography) contributing to unrealistic expectations, fostering sexual problems	6	17.6	0	0
	Prominence of sex/sexuality in technology and media, influences client	3	8.8	0	0
	Negative influence of technology (i.e. as distraction, as impeding embodiment, or interpersonal communication)	4	11.8	0	0
	Positive/mixed influence of technology--new information technologies (esp. internet) may contribute to a more informed client population	1	2.9	1	2.9
Interviewee emphasizes importance of mentalizing capacity (esp. reflective functioning) in client		4	11.8	5	14.7

Table 8.1 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Clinician sees therapy relationship as fostering mentalization/reflective functioning or mirroring outside relationships	4	11.8	0	0
	Maladaptive thoughts/beliefs seen as causal factor	2	5.9	0	0
Clinician works to identify an unconscious function/meaning of the client's symptom		11	32.4	3	8.8
	Therapeutic work explores meanings the client attaches to sex/sexuality	5	14.7	1	2.9
	Interviewee identifies client's fear/ avoidance of intimacy or sexual contact as a causal factor in the sexual problem	4	11.8	1	2.9
	Interviewee states that, for psychoanalytic practitioners specifically, discomfort discussing sex is common	1	2.9	0	0

Table 8.1 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Repression seen as a contributing factor in sexual problems		5	14.7	4	11.8
	Interviewee sees avoidant defense as affecting therapy	5	14.7	1	2.9
	Resistance--clients often resist treatment/ change process	2	5.9	1	2.9
	Couple members may collude in resisting change	3	8.8	0	0
	Clinician may collude with client in resisting difficult work (impedes progress)	1	2.9	0	0

Table 8.2

Aetiological factors: themes and sub-themes identified in research interviews, including representative/characteristic statements

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes that aetiology is multi-factorial	7	20.6	I don't think that we can just point and say: 'oh, well this is the cause'. There are many reasons for why a problem arises. I try to teach people how to find the themes so that you're looking for the broad, overriding ideas that might underlie the different problems. So that's, this is really the hardest issue: asking the questions, hearing the information, and then beginning to try and find a picture that explains—in your mind—an explanation that explains it all without narrowing it down to just two or three simple things
Outside life factors (professional, personal, etc.) contribute to sexual problem	4	11.8	Often, there are a number of things compounded on each other--it could be relationship issues, there could be other things going on in the family, there could be job stresses…that's one of the reasons I've never gotten bored with this workere could be job stresses...that's one of the reasons I've never gotten bored with this work

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Causal factors seen as overlapping	2	5.9	a person may come in and say that: "my partner is not interested in sex with me anymore" or "I'm not interested in sex anymore". And so it looks at its face like a desire issue. But when you start exploring where it began you may see, and it's often that you see, that it may have started with pain on intercourse, or it may have started with erection problems and anxiety about not having erections, or not being able to perform, or not being able to have an orgasm in intercourse. What happens is the two people drift away from each other. And so you end up with what looks like a lack of interest in sex, it is, but the actual sexual symptom—the original sexual symptom—is something very different.
Clinician emphasizes client's early life (as affecting current relationships and sexual functioning)	24	70.6	Generally, in my experience, the sexual disorders arise out of background and experience. And are not something that happen in the adult life spontaneously. the sexual map gets laid down starting at a very early age. Past experiences of intimacy. In other words, I think that growing up in a dysfunctional home sort of primes you more for having sexual difficulties. A history of anxiety disorders or depression…I think all of these things can prime you.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician focuses on client's family of origin in assessment and treatment	22	64.7	what specific key issues have emerged from childhood that might be very sensitive points for them? For example, they might have had a difficult relationship with the father which now affects the way they choose partners. There's a whole raft of people out there who've had really poor role models—because where we learn about sex and sexuality, and intimacy and closeness, is our own families of origin. If our own families of origin have been dysfunctional—working with a client at the moment who simply has never been able to connect that married people are also lovers, because she had simply never seen her parents be affectionate, or caring of each other

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician uses a developmental focus	6	17.6	We need to develop people all the way up from very young developmental stages through, so they can be adults out there having sexual contact with each other. to be a [therapist] who is not mindful of development, who thinks they can take care of sexual problems, either strictly biologically like a urologist might think, or a gynecologist might think, or strictly behaviorally, I just think that's incompetent. I want to know: have they always been like that? The usual sort of thing, you know: how long have they felt like that? What were they like in—and then I usually go backwards, so: "do you remember what you were like in school, in primary school?" "Yes, da, da, da, da". "What about kindergarten, what were you like then?" Then I might go to: "were either of your parents shy, or introverted people, because often that's the case". And it might be that I would go through all that and find that no, everything was fine, and suddenly when they got to puberty, or high school here, something happened.
Therapy focuses on influence of early life parental relationship over current sexuality	10	29.4	we would talk about their individual history, that perhaps, for example, they came from a very religious family where sex was not discussed and where it was difficult to get sexual information, or where sex felt like a sin or wrong or whatever it is. Or where people were, on the other hand, too open, there were no boundaries it felt. So we would think of those sort of earlier issues. in terms of working with my clients, we go back to how they learned about sex and how their parents--responded to their sexual interests.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Therapy focuses on client's attachment relationships/attachment style	15	44.1	We are very interested in the development of the person, because we have an assumption that the dysfunction has something to do with the person's understanding of the world, understanding of him or herself, and what happened—what anxieties they have about attaching to another person. That is, the genital organs function is attachment, not just pleasure. I work with creating-secure-attachment stuff...the whole concept of secure adult attachment has become very, very big in the marriage and family field .

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Focus on client's relationship schemas, models or scripts	12	35.3	when I first see a client I would say to them that when we're born we don't know anything about sex or about relationships. And so everything that each individual thinks, feels, believes today is based on all sorts of things that have gone on around them, things they've heard, things they've witnessed, things they've interpreted as they've grown up. And we then usually spend one session of assessment going over their life history to try and identify what their particular story is. And then if you're working with a couple, you would obviously do that with both partners, and put the whole lot together, and sort of use that to make sense of what it is they've learned, what it is they've assumed, what it is their expectations and their blueprints are based on. you often get a pattern where one partner goes into so-called 'critical parent', and the other one goes into child, into scripted child. So, you can get one partner driving the sexual relationship, and a case to illustrate this: the woman was very controlling in the room, tried to control me, you know, complained that I wasn't doing the therapy right, wasn't getting results fast enough. And the man was really quite passive in the room.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes the significance of past trauma (and its possible influence on current sexual problem)	17	50.0	Traumatic past experiences, you know, molestations, or invasive medical procedures when you're a kid that make you feel a lack of control--those are the kinds of things that I think prime people [for sexual difficulties] 278-9-- several of my clients...have been abused in one way or another [as children]; that's a constant theme in my practice. quite a high proportion of my patients have experienced some degree of trauma. Not necessarily overt abuse, but perhaps a child's interpretation of something traumatic. what some therapists do is: they'll zoom in on something like a trauma accident. Or they'll zoom in on a past childhood, and they stay there forever. But one of the decisions you have to make is: where can I do the work? I'm here to make changes—what sort of work can I do?

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes religious background's potential influence on sex/ sexual functioning	14	41.2	Religion and culture, I think, can be very influential. I get quite a high proportion, as I've said, of people [from] Roman Catholic backgrounds, or particularly evangelistic and rigid religious beliefs, where sex can too easily be seen as dirty or not acceptable. most religions that are fiercely protective of premarital celibacy, abstinence, probably…end up sometimes with more pressure on the newly married, or even the premarital experience. What I mean is I've seen men…who are about to get married, who are really frightened and concerned about whether they'll be able to perform, because they have no sexual experience. it's useful to have religious leaders you can refer to, because I find people often hide behind their religion. They're sort of misinformed on what their religious guidelines really are.
Emphasis on spiritual aspect of sexuality	4	11.8	I'm very much of the new view point of view, which is that: we can't make the body into this sort of, separated from our mind, emotions, and our spirituality. [I] have used [an] integrative model that looks at phenomenological experience. It also looks at physiological reaction. It looks at behavioural changes. It looks at attitude. It looks at spiritual self as well. So it's very much an integrative model. desire to me is not the same as appetite, and it's not the same as my body's showing signs of arousal. It's really, as I say, it's this very complex: it's really body-mind-spirit-emotions, all of it.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes possible benefits of involving a religious/ spiritual leader in therapy	3	8.8	it's useful to have religious leaders you can refer to, because I find people often hide behind their religion. They're sort of misinformed on what their religious guidelines really are. I saw one couple that had seen a quote "marriage counselor" for a year and they told me "yes" that he had dealt with the sexual issues as much as he felt he could, and when he couldn't he referred them to the doctor, and guess what kind of a marriage counselor he was? A Catholic priest.
Interviewee sees depression as causal/ caontributing/underlying factor	9	26.5	Anxiety and depression [are] hardly ever unrelated, as far as I'm concerned, to sexual and relationship issues. One of the symptoms of depression is depressed libido for many people. sometimes [clients]came in with a sex therapy complaint, and it turned into a much more general treatment for...depression, right? And if they came in and said they were depressed, you might have found that part of their depression was based in some pretty serious sexual difficulties, so you had to switch gears.
Lack of privacy as a contributor to sexual problems	2	5.9	[Important contributors include] Geography and privacy...for some people, the fear of being overheard, you know, environmental factors...The sense of being disturbed, by whatever…the stuff that's going on in their environment around them.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Knowledge/skills (i.e. psychosexual skills) deficits as contributing factors in sexual problems	13	38.2	there's something about how we as a society teach people about their sexuality, and the range of normative behaviors. And the role of sex and physical intimacy in a healthy relationship, that just isn't working well. And it's not lack of awareness of sex—you know, sex is out there in our media all the time. It's something about the beliefs, and confidence and skills and knowledge that we give people that just isn't sufficient. the biggest problem [was] lack of information, misinformation, that people were afraid of sex because of things—you know, mommy or daddy said to them: if you masturbate, your hand's going to grow hair, you're going to need glasses, all that kind of crazy stuff that we laugh about now, but that many people thirty years ago still believed, and you'll still find a few people now too. So many times [I hear]: I just never knew that was normal, I never knew that was ok, I never knew that was possible, I had no idea.
Interviewee sees anxiety as causal/contributing factor	17	50.0	[One contributing factor] could be old anxiety, so that there may not even be awareness of where that anxiety comes from. That's what I call autonomous. An autonomous emotion, where you don't have any—you can't identify where it's coming from, but it is almost like a classically-conditioned response to a sexual situation. [Causal factors include] fear, insecurity, performance anxiety, and pressure. With men, a lot of times, it's performance anxiety.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee sees guilt as an aetiological/influential factor in sexual problems	7	20.6	It's like [clients] have been brought up with guilt from childhood. [Your upbringing] has caused you to have some unhelpful views about sexuality… particularly guilt. Now, by getting involved with another woman so quickly, suddenly it's almost like [the client is] being unfaithful to her. Ok? So, put together, lack of grieving, feeling unfaithful and guilty, why would he get an erection? Do you quote-unquote 'cure' them from the guilt? Here's my response to that: I don't think you ever can, not fully...but you can make someone understand where it comes from...So, you make someone aware of: what is it? Why do you feel guilty? And then, of course, you know, you tell the person time and time again: no, it's not bad, it's not bad, it's not bad, you know? Because usually people feel guilty about stuff that's normal.
Interviewee sees shame as an aetiological/influential factor in sexual problems	9	26.5	We look at…erotic conflicts--[sexual] behaviour being driven by unresolved shame, or guilt. Sex can trigger shame in us anyway. That seems to be, anthropologically, everywhere you look. We have sex in private. We're the only animal that has to have sex in private. Shame seems to be around. Toxic shame--it's everywhere. It's the foundation of all the sexual problems.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee believes that, for clients, discomfort (i.e. shame or sense of stigma) discussing sex is common and affects treatment	6	17.6	sex is a subject that is often quite taboo. It still amazes me, so many years into my practice, the difficulty that couples, and sometimes individuals have, in communicating about sex.
Interviewee stresses the benefit of client disclosure (to prospective partner)	1	2.9	I favour encouraging the single males, when they're given prescriptions for, say, Viagra, that the doctors counsel them: "look you're not going to get further ahead, necessarily, or be more comfortable with your life, if you are not going to let your partners know that you use it."
Disclosure of sexual problem (to therapist) may occur later in therapy	2	5.9	it's quite common, because sex is so difficult to talk about...for couples not to disclose that there's a sexual problem, until they've worked with you a while...so we may not find out about the sexual problem until later.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Importance of the therapist initiating discussion of sexual aspects	4	11.8	often [sexuality is] something that needs to be explored directly by the therapist. I can think of circumstances in session where for the first few sessions with a couple nothing comes up about sex whatsoever. And then until I essentially realize that this topic has not be broached yet at all, and I'm the one that at some level points it out, and then I realize how much is behind it, and how much stigma is attached to it, and shame. And how little people are comfortable talking about it. people would say they had seen a therapist or a marriage counselor, and some of them had seen them for a couple of years. And I'd say: 'well, how did you deal with this sexual issue?' And I'd get a blank stare. And they'd say: "they never ask about sex". And I used to think: how in the world can somebody go to marriage counseling and never ask about sex? if they're not presenting with a sexual problem...I will always ask about the sexual aspect of the relationship.
Importance of therapist being comfortable/ competent to discuss sex/ sexuality	4	11.8	What is crucial in terms of the sex issues is to be able to talk about, directly with the client, their attitudes, their experiences, their emotions. the therapy begins with an evaluation that has a respectful, comfortable environment that allows the patient to talk and tell his story. So this whole process that I'm talking about really requires you the therapist to be comfortable with your own sexuality.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician emphasizes cultural factors' influence on sex/sexual functioning	17	50.0	I think sex therapy, like therapy, is really—it's a celebration of the individuality of the person. And it's getting beyond these cultural stereotypes, recognizing that culture does shape people's sensibilities and, I would say, their values. Culture is really, really important...for a whole range of things. For example, the language people use in sexuality can really depend on the culture they come from. And culture can influence how we look at relationships.
Clinician considers the influence of sexually restrictive cultural factors	8	23.5	I don't know any culture that doesn't restrain sexuality somehow. It just depends on what culture you're in. And you're going to understand through the shaming process that some expressions of sexuality are not good. They are not to be expressed, and if you do there will be punishment and shame. It just depends on which culture you're in. So, sexuality, on some level, is curtailed. And I think many of us humans, we wish to live in a society where sexuality was less curtailed. the lack of understanding about sexuality is often compounded by our culture's uneasy relationship to sexuality and sexual pleasure. that distress [about sexual dysfunction] though, is mostly because they're in a society that doesn't accept it, which is perpetuated by having it in books like [the DSM].

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Sex-negative messages seen as prevalent in Western culture	4	11.8	No sexuality is seen as normal in the United States...United States history goes back, and is still affected by the puritans, who are some of the earliest settlers in the US. And their values and so on still tend to colour American culture and politics. It comes directly from the Victorian era, and religious belief that children are meant to be innocent and that sex is dirty, and that children should not be allowed to masturbate. That any kind of sign of sexual interest in a child is abnormal, and that the parents should punish it and treat it with scorn.
Sexual difference/non-conformity equated with pathology in Western culture	5	14.7	What pathology and pathologizing implies, is taking something that is normative, something that is within a healthy, normative expression range, and making it wrong. some of [the treatment] will be the normalizing process, as well, of saying: look, everyone who comes here struggles with this kind of stuff. It's not, really, it's not just you. It's kind of everybody. some of the men come for out-of-control sexual behaviour [treatment] with these completely unexplored, unexpressed, very hidden erotic interests and lives. And live in a very sex-negative world. And…the addiction model is another form of disapproval of who they are erotically...it just perpetuates the mindset that non-conformity in one's erotic nature is pathological. lesbian and gay people have really struggled to have rights, they've been pathologized, they've been criminalized, stigmatized.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Sexual media (esp. pornography) contributing to unrealistic expectations, fostering sexual problems	6	17.6	All we have is these hot sex images from movies, and ideas people have in their heads—porn being one of the best places for people to get these ideas—that, if they're not having hot sex, and you're not ripping each others' clothes off, something is terribly wrong, and we're not in love anymore. these days, probably, unrealistic expectations have led to more performance anxiety in young people.
Prominence of sex/ sexuality in technology and media, influences client	3	8.8	the internet has really, I think, brought erotic interests forward in people's minds, in a way that we've never had to deal with before in the history of humanity. You know, now somebody can go online, and look at an image, and discover their erotic nature, much sooner, more rapidly, more intensely than ever before.
Negative influence of technology (i.e. as distraction, as impeding embodiment, or interpersonal communication)	4	11.8	culturally, systemically, people are being forced into a techno-mind world. Too much virtual, not enough physical embodiment. I think the internet—is very powerful [in creating problems], anything that distracts people, that takes them out of it. we are losing the ability to communicate on a face-to-face basis. You know, we've got an awful lot of texting going on, a lot of emailing, a lot of facetiming and twittering, and even youtube is a way of communicating now, it would seem. But I think a lot of people are losing the ability to just be with somebody, without there being a screen or a touchpad of some description around.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Positive/mixed influence of technology-- new information technologies (esp. internet) may contribute to a more informed client population	2	5.9	we got the internet in that period of time, people started doing more research about their sexual problems, and so the issues, and the types of referrals became much more focused on a specific sexual complaint to the point that, I had people come in lately that they would use even medical terms, knew that they had been on the web, and checking this out. [There are] more self referrals of late, and I'd say better educated because of the internet and because of just the amount of books too that are out now on sexual dysfunction and sexual disorder

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes importance of mentalizing capacity (esp. reflective functioning) in client	9	26.5	what I'm doing is telling a person a way of understanding a relationship at least in one dimension, so that they can see from the other side and use a different model of thinking. I'm trying to create an observing ego, that will enable the individual to start to see the patterns of their relating. We might, I suppose, relate that to the idea of mentalizing. What I think happens in a mentalizing point of view in sexual dysfunction is that the couple get into each others' minds very often, in extremely non-mentalizing way, and then they start behaving according to their poorly mentalized representation of the other, and as a consequence, make the other behave even worse, that reinforces their poorly mentalized experience of their behavior. And what you've got to do is say: "hold on a second, it's not so bad. You know, let's just stop, and let's talk about penises." Once you actually start talking about the machinery, as it were, paradoxically what you're doing is not downgrading the discourse, in terms of making it physicalistic, but putting it in the appropriate box. Putting the physical into the physical box, and the mental in the mental box.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician sees therapy relationship as fostering mentalization/ reflective functioning or mirroring outside relationships	4	11.8	what happens in the dynamic in the room, either between the three of you, or between two out of the three of you—and quite often when I'm working one-to-one with one client, not a couple... those moments may mirror what's not going well in their outside relationships. my job, as I see it, is getting in and understanding and showing the couple that--what you're doing here mimics what you do out there. And that--if you can just stop and pause for a moment and realize how automatic this is, you can take it off autopilot and ultimately change it. so suddenly the experience of a [client-therapist] relationship that's focused on the client can offer a template in which they can say "does the relationship I'm involved with with this other person also help me to reflect on what's best for me?"
Maladaptive thoughts/ beliefs seen as causal factor	2	5.9	I think that a lot of [the client's sexual problem] has to do with all kinds of nonsense that people tell themselves. Whether they've learned that nonsense at their parents knee, or their pastor's knee, or on the cover of cosmopolitan magazine, they still have some really bizarre ideas about men or women, or how sex is supposed to be conducted.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician works to identify an unconscious function/ meaning of the client's symptom	14	41.2	Often there's a… "function of the dysfunction". And looking for that is often important...that's where you see the resistances. one of the things that people need to think about, and this also comes through in some of the psychoanalytic literature as well, is that if a symptom is fixed and specific, Michael, one of the things that you have to ask yourself is: what is the function of the symptom? How does it serve to stabilize the person? How does it serve to keep the person functioning? I would involve them looking at…"what's keeping this going for you? What's your interest in still maintaining this symptom?" if there's no movement...then I have to go back and reassess...Is there a larger issue here that the symptom is not ready to be removed, because it's serving some stabilizing factor that I haven't picked up on? If you remove the symptom too quickly, you change the person's perspective of themselves, the world, their experience, and that can actually create an avalanche of psychic pain and structure that they're not prepared to deal with. So, a key idea here is: always respect the symptom. Don't necessarily assume it's an indice of pathology. Because it might be how the person has learned to survive under circumstances that—for many other people they might have given up. That's what I mean by 'respecting the symptom'.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Therapeutic work explores meanings the client attaches to sex/ sexuality	6	17.6	I think that sex therapists get, you know, so caught up in—you know, how does your dick work, how does your vagina lubricate—as opposed to: what is the meaning that's driving the behavior? Now, for me, there isn't a psychodynamic bone in my body. So, what I think is important, though, in terms of the translation, is understanding the different experiences and meanings of sexuality that people have. Whether it's from the culture, from their family, from childhood sexual trauma. what you're asking them to do is not just let it be at the genital or somatic level. You're asking them to begin weaving meaning around that experience. Not just in the therapy, but it's something that they can weave into their life.
Interviewee identifies client's fear/avoidance of intimacy or sexual contact as a causal factor in the sexual problem	5	14.7	With another client, I think there was something about being intimate, getting too close to someone, leads to a sense of suffocation, and no freedom from parents, from the mother, actually. you might ask someone about a sexual problem and you get a hint from their answer that they actually might have issues with, say, intimacy. I said...: "you are actually avoiding real intimacy with an adult partner". another case that started off as counseling and became sex therapy and has just ended very successfully a few weeks ago: the man avoided feelings, for various reasons from his past, and so the pattern that they had was that he would invite her to have sex, but in a jokey way...and she would feel resentful.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee states that, for psychoanalytic practitioners specifically, discomfort discussing sex is common	1	2.9	The early psychoanalysts were utterly devoid of shame or fear. They broke every taboo. So to go into the details of Onanism as it would have been referred to in those days, was part of their bread-and-butter work. And something has happened over the course of psychoanalysis...over the transformation of Freud's very radical, you know, shocking-the-bourgeoisie revolution, really, in terms of sex...And you find an extraordinary anti-sexual conservatism creeping into all of psychoanalytical discourse, and sexuality almost drops out.

Table 8.2 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Repression seen as a contributing factor in sexual problems	9	26.5	Most children are taught to repress sexual feelings using mechanisms of shame or guilt. people misunderstand, in the clinical community, what repression is. But repression is at play in many, many processes in life. It's just things that are out of awareness that have some psychodynamic importance. There's an avoidant quality to it. So I think that plays a large role. I talk about one woman who was diapering her six month old baby, and grabbed his penis with absolute delight, and her mother was watching and she raised her hand to remove the boy's hand, and the child's mother grabbed her mother's hand and said "don't you dare do that to my son. He's allowed to touch his penis and to enjoy it". And she said that she felt that she had prevented a socially sanctioned form of child abuse. Sexual child abuse. So there it is, you know, sociologically. And in terms of working with my clients on this, we go back to how they learned about sex, and how they—how their parents—responded to their sexual interests.

Distinctive Cognitive Behavioural Therapy and Psychodynamic Psychotherapy Techniques

Distinctive Cognitive Behavioural Therapy Techniques:

1) Therapist discusses specific activities or tasks for the patient to attempt outside of the session.
2) Therapist encourages the patient to try new ways of behaving with others (i.e. sexual partners).
3) Therapist behaves in a teacher-like (didactic) manner
4) Therapist uses/prescribes sensate focus exercises (with a patient who has/had a sexual partner).
5) Therapist uses/prescribes intercourse prohibition.
6) Therapist uses/prescribes directed masturbation exercises.
7) Therapist uses precise and fixed time limits.
8) Therapist uses use systematic desensitization.

Distinctive Psychodynamic Psychotherapy Techniques:

1) Therapist discusses/examines the patient's fantasies and/or dreams.
2) Therapist points out/illustrates the patient's resistance to treatment (i.e. defensive maneuvers, such as denial).
3) Therapist examines/explores the patient's unconscious thoughts/feelings.
4) Therapist discusses the therapy relationship (i.e. the relationship between the therapist and the patient) with the patient.
5) Therapist draws attention to feelings the patient may regard as unacceptable (i.e. anger, envy, etc.).
6) Therapist focuses on the patient's feelings of guilt.
7) Therapist works to help the patient resolve internal conflicts.
8) Therapist examines the patient's formative (earlier life) experiences as influencing current relationships/sexual functioning.

Table 9.3

Use of psychodynamic and psychodynamically-linked theories and techniques: number and percent of interviewees discussing theme/sub-themes explicitly and implicitly

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Interviewee states dislike of psychoanalysis, or skepticism about the efficacy of psychoanalysis		2	5.9	1	2.9
	Interviewee conflates Freudian Psychoanalysis and Psychodynamic Psychotherapy	2	5.9	0	0
Clinician focuses on unconscious factors in treatment practice		16	47.1	3	8.8
	Interviewee sees unconscious patterns of thought/affect/behaviour as affecting sexual problem	14	41.2	0	0
	Therapist works with transference/ countertransference	9	26.5	0	0
Clinician makes implicit use of psychodynamic techniques		4	11.8	0	0

Table 9.3 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Psychodynamic techniques used on an ad hoc basis	6	17.6	0	0
	Clinician identifies client as narcissistic	4	11.8	0	0
	Reference to infantile sexuality	2	5.9	0	0
Clinician views increased insight (for the client) as an overarching therapeutic aim		10	29.4	3	8.8
	Clinician emphasizes new/different perspective (for the client) as a therapeutic aim	4	11.8	2	5.9
	Clinician seeks to understand individual's erotic schemas (i.e. "arousal template"/"core erotic themes")	3	8.8	0	0
Interviewee emphasizes that it is important for the client to understanding psychosocial causal factors/aetiology		10	29.4	3	8.8

Table 9.3 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Critical internal voice (esp. parental) seen as a common contributing factor in sexual problems	2	5.9	0	0
	Emphasis on the influence of projection (blaming/projecting) or projective identification onto partner	6	17.6	0	0
	Emphasis on the influence of projection onto therapist	1	2.9	0	0
Clinician uses relational model of psychoanalytic/psychodynamic practice		2	5.9	0	0
	Psychodynamic techniques link past to present	4	11.8	0	0
	Therapist feeling counter-transference feelings towards older clients	0	0	1	2.9
	Interviewee believes psychodynamic intervention provides more enduring change	2	5.9	0	0

Table 9.3 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
	Clinician uses interpretations (psychodynamic)	5	14.7	0	0
	Clinician is tentative in use of interpretations	1	2.9	1	2.9
	Psychoanalysis and sexology seen as disconnected	2	5.9	0	0
	Clinician works with patient's/client's fantasy as clinical material/content	6	17.6	0	0
	Clinician works with patient's/client's dreams as clinical content	2	5.9	0	0
CBT and psychodynamic techniques seen as naturally overlapping		1	2.9	1	2.9
	Sensate focus exercises may trigger developmental/attachment issues	1	2.9	0	0
	Therapist challenging client defenses too much/soon risks reinforcing them	1	2.9	0	0

Table 9.3 (continued)

Themes	Sub-themes	Interviewees discussing theme/sub-theme explicitly		Interviewees discussing theme/sub-theme implicitly	
		Number	Percent (%)	Number	Percent (%)
Importance of (both couple and individual) defense mechanisms		6	17.6	3	8.8
	Displacement	1	2.9	0	0
	Intellectualization	1	2.9	0	0
	Therapist examines/considers client's inner conflicts about sex (i.e. values, behaviours, beliefs, and meanings)	2	5.9	0	0
	Somatization seen as important in sexual problems	1	2.9	0	0

Table 9.4

Use of psychodynamic and psychodynamically-linked theories and techniques: themes and sub-themes identified in research interviews, including representative/characteristic statements

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee states dislike of psychoanalysis, or skepticism about the efficacy of psychoanalysis	3	8.8	Interviewer: "how would you see psychoanalytic methods?" Interviewee: "I consider it narcissistic self indulgence".
Interviewee conflates Freudian Psychoanalysis and Psychodynamic Psychotherapy	2	5.9	in psychodynamic or psychoanalytic, it would be, you know, you get the interpretation spoon-fed to you by the analyst, and then you can either reject it or take it in, and if you reject it then the analyst deems you as resistant, because the analyst has all the power. I mean, it's such horseshit.
Clinician focuses on unconscious factors in treatment practice	19	55.9	there are unconscious processes between the couple. You can have a couple who, when you begin to peel back the layers of the onion, actually, quite often with loss of desire there's an underlying power imbalance that hasn't been expressed There's an unconscious motivation beneath every sexual act, which often has nothing to do with the obviousness of the sexual act. That's how I think about this, and how I've come to think about this, through the work.

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee sees unconscious patterns of thought/affect/ behaviour as affecting sexual problem	14	41.2	in our approach we see the sexual behaviour, first, as a manifestation of unresolved, unconscious, and quite distressing attachment patterns, and ways of coping with connection and closeness with people. . he found all sorts of different words that were saying nothing about what he kind of got out of it. But what is it, if you really, really drill down into the behaviour , that you're getting out of it? What are you avoiding? But also, what are you getting out of it? What is it fulfilling? What is that deeper need, that is not sex, that it's actually fulfilling? And that does, yeah that does take a lot of self-reflection to kind of do that piece.

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Therapist works with transference/	9	26.5	It's huge. Clients will always hang their images, and fantasies and transferences on some peg, however neutral you are. So I don't believe we are there as blank slates. We have to use who we are purposefully. we don't talk about transference as much, and transferential issues in sex therapy because there are usually two people, but it happens. And I remember one member of a couple saying to me once that: I wish we had a paper cutout of you in our bedroom. And I immediately discouraged that. And I said, as Dr. Kaplan would have said, I think: I'm just a mirror, I'm just here to reflect what you're experiencing. family transference comes when there are unresolved family issues, when there's resentment toward one, one parent or both, or siblings. And you know when two people fall in love, you fall in love with a stranger, you fall in love with somebody new and exciting and different. And somebody who completes you in some ways. And then when you make a commitment to that person, and particularly when you move in together, and set up a household together, one of the things that often happens is that they start to re-enact their own family situations. So, how they've been programmed in their original family is now how they begin to interact...And I point that out to a lot of people. Because I always ask for three adjectives to: describe what it was like for you to grow up in this family, when I do the family history. And I will point out to them that those three adjectives that they use to describe their original family can also be applicable to the relationship they now have with their current partner.

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician makes implicit use of psychodynamic techniques	4	11.8	when I say, when I talk about deeper, [psychodynamically] oriented approach, it isn't necessarily changing the mode of therapy, it's just attending to things that occur in one's early critical period experience

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Psychodynamic techniques used on an ad hoc basis	6	17.6	the psychodynamic stuff, well that's all about unconscious processes, unconscious fit, the types of—if you were in transactional analysis—the types of games that couples play. Because those can be, often, the maintaining factors that haven't helped them fix the problem for themselves. when we get to things like loss of desire, we need to bring in ideas from psychodynamic counselling" if I'm totally honest, I suppose my psychoanalytic background certainly reared up and down every once in a while. Did I throw Freud out? No. He still had a few good things to say. I don't think Sigmund Freud used photographs, but I was able to use a more psychoanalytic approach to those, and what I would ask people to do, is: "why don't you bring some pictures in?" And they said, "well, what kind of pictures?" And I'd say: "you decide. What's important to you?" So, again, you're putting the choice back on the patient... Because then you'd find out, if it was a picture of her as a little kid, who's the person behind the camera, who's looking at them? So, there was a lot of psychoanalytic style in a technique that was obviously a more modern technique. But my use of it was much more based in psychoanalysis. On the same score, a very narcissistic young man came with 8 pictures, all of them of him and, interestingly enough, with no one else in the picture. It was always just either a studio portrait of him, or a snapshot of him, and when I commented on this, I said: "interesting, you brought in only pictures of yourself", he got real angry, and real defensive and said: "well, you told me to bring in pictures of me". Of course, I never said pictures of you, I just said 'pictures'. So, again, it gave you an opportunity to use a more psychoanalytic approach

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician identifies client as narcissistic	4	11.8	a very narcissistic young man came with 8 pictures, all of them of him and, interestingly enough, with no one else in the picture. It was always just either a studio portrait of him, or a snapshot of him, and when I commented on this, I said: "interesting, you brought in only pictures of yourself", he got real angry, and real defensive and said: "well, you told me to bring in pictures of me". Of course, I never said pictures of you, I just said 'pictures'. So, again, it gave you an opportunity to use a more psychoanalytic approach. it wasn't that he was a quivering wreck, or—you know, his hands didn't shake. But he was very narcissistic. He had an enormous vulnerability. So, he was extremely concerned about what I thought about him, and what anybody thought about him. Someone who is, let's say, narcissistic. Then I am in the role of being in agreement with them. I am a mirror that is as accurate as I can be of their experience, and that's in the service of creating the sort of trust, which I may need to do in that context.
Reference to infantile sexuality	2	5.9	look at a baby. A baby is just going to lie there in its little crib. And hopefully it's snug and safe and secure. And it's going to start exploring its genitals. And it's going to start feeling that something is good, right? And it's going to probably masturbate, and that's all going to be good, and then the baby's going to feel pleasure, and it's going to be like "yayy", you know? Now, fast-forward—that same kid does that in front of other people...and the kid is like four years old, right? You telling me that the mom or the dad, or some other adult isn't going to walk up to that kid and say: oh no, we don't do that. That's private.

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician views increased insight (for the client) as an overarching therapeutic aim	13	38.2	treatment is based on an understanding of a person, and the use of the self as a supportive, kind, educative, illuminating person that helps the person come to grips with, and understand, the psychosocial origins of their dilemma, their sexual dilemmas. My job is for an individual to work out who they are, and how they tick...looking at their childhood and gaining insights from the messages they've received, the internet, parent role models...early memories, potential traumas.
Clinician emphasizes new/different perspective (for the client) as a therapeutic aim	6	17.6	[The process entails] shifting perspective; another image would be of the spiral staircase. We come back to the same problem. Why is it we always have to come back and talk about the same problem? The patient worries about repeating themselves ad nauseam. And I say: "well, it's a spiral staircase, you know? Maybe we're looking down at the same stuff but the perspective's a bit different as we move along the staircase".
Clinician seeks to understand individual's erotic schemas (i.e. "arousal template"/"core erotic themes")	3	8.8	I ask them to tell me: what are your fantasies…what is that core erotic theme? And then I identify the core erotic theme for them, and that seems very productive.

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Interviewee emphasizes that it is important for the client to understanding psychosocial causal factors/aetiology	13	38.2	I would never then simply throw him into one of these so-called programs, stop-start for example. Because, why? Because there are all kinds of psychodynamic that are likely to be happening. We still need to work out: what was the cause of this? He does need to look at his feelings about sex. He does need to look at where this has come from. if someone was sexually functional, say, for five years, and then developed a problem—then we want to explore the disappointments, and the tensions, and the dilemmas inherent in their relationship.
Critical internal voice (esp. parental) seen as a common contributing factor in sexual problems	2	5.9	He felt that his father would have been extremely negative about him…his father died when he was age 13, and he carried on this memory of his imagined disapproval. I wouldn't say his actual father, but the father that he experienced was somebody rather masculine and intolerant of femininity in the male gender. quite often clients are experiencing depression, anxiety stuff as well as the sexual stuff, you know, as we explore those experiences, we kind of see how much they've got critical voices going on all the time

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Emphasis on the influence of projection (blaming/ projecting) or projective identification onto partner	6	17.6	I will use projection and projective identification. So where one member of the couple is perhaps blaming the other one for the sexual problem, helping them to see that there may be some projection there can help. In sex therapy, the projection can be guilt: one partner is carrying the guilt. You know: it's all my fault. And seeing that maybe it's not just them, and the other partner has a part in this as well". So, he identifies with her, and in his rescuing of her he is identified with her experience and is able, because he doesn't help himself, he helps the other person and in helping the other person he is able to experience some benefit himself. So this, as I would see it, is a form of projective identification.
Emphasis on the influence of projection onto therapist	1	2.9	I think projected onto me was this kind of paternal transference of somebody who would not think very highly of my patient.

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician uses relational model of psychoanalytic/ psychodynamic practice	2	5.9	one of the things that comes up, at least for me, in contemporary psychoanalytic theory is: the focus on the co-creation of the experience with the client...I think psychoanalytic theory picked up and said: wait, what's the affective experience of that cognitive connection? So I think part of what's important in the psychoanalytic piece is really returning to the relationship...they know that you're responding emotionally to their experience as well. if I have a technique to bring it's the psychoanalytic method. It's the psychoanalytical ethos. I'm not saying that you can only treat sexual problems in classical psychoanalysis. I don't think that's true...I don't think of myself—and probably most of my colleagues in the analytical world wouldn't think of themselves—as having techniques or methods or strategies beyond encouraging the psychotherapeutic process to unfold in its classical way, with perhaps a more modern, compassionate viewpoint about human behavior.
Psychodynamic techniques link past to present	4	11.8	where relationship issues come up--and…I work with relationship quite actively--I'll go into psychodynamic methods to untangle that. I think it mainly focuses on influences of the past, because that's where psychodynamic theory, I think, is particularly helpful. in this case, I've used a sort of psychodynamic approach with the man...I helped him to understand, I believe, that his guilt comes from his childhood: a very dominating father, and a somewhat submissive mother. And a lack of love in the family. And so we put together an explanation that perhaps he's not experienced giving and taking love, or receiving love.

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Therapist feeling counter-transference feelings towards older clients	1	2.9	in the last perhaps two years, I think I've probably seen a lot more older clients in sex therapy than I have younger clients…I had to overcome my: "oh gosh, this is like talking to my mum and dad about their sex life" feeling.
Interviewee believes psychodynamic intervention provides more enduring change	2	5.9	my work would start off…more loaded on the psychodynamic front, because the early days are about finding insight…you need to have insight, otherwise the problem surfaces again.
Clinician uses interpretations (psychodynamic)	5	14.7	I have made the odd interpretation where the sexual symptom has disappeared with one interpretation, and it's helped overcome an inhibition. [One client] much preferred having a prejudice. To say, well, you know: "you're useless", kind of thing. And "what use is this? What use is me talking about my father? He's dead...what use is me talking about my relationship with you?"...I remember interpreting it—maybe he was concerned that somewhere I harboured some of the prejudices [of his father], and that I would try to convert him into something.

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician is tentative in use of interpretations	2	5.9	you have to be very tentative in your interpretations. You can't go for the jugular, as they say. I'd say: "I'm not here to interpret your dreams. I'm here to get YOU to interpret them". So, if you drew out some associations, frequently you could get people to interpret their own dreams.
Psychoanalysis and sexology seen as disconnected	2	5.9	the world of classical psychoanalysis, and the world of modern sexology, although they have had dates, they've never had intercourse as far as I know. there's a tremendous amount of hatred between the two organizations. I'm writing a book now about love, and psychiatry, and psychoanalysis' avoidance of love as a topic.

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician works with patient's/ client's fantasy as clinical material/ content	6	17.6	[Working with material from the client's fantasies] is a mainstay of my psychotherapeutic work with individuals, and with couples. It is much harder to do with couples, because there are three people in the room as opposed to two; two of whom sleep in the same bed every night, so that's a very, very delicate dance. we may well split the couple up--fantasy is something that's often quite difficult to discuss as a couple. it's all about meaning. So, you know, if somebody has a dream. And I think there should be way more about sexual fantasies from this perspective, but it's just what we were saying about multiple meanings...it would be really interesting to [question]: "what are the meanings of the different elements for you, of that fantasy?" And the same with an actual dream...whether it's a sexual one or not...to sort of look at the key elements and think, "you know, what does that mean? So, that particular fictional character that you fantasize about--what does he or she mean to you? What do you associate with them? What do they represent?...You start with the phenomenological: "let's get a description of this whole dream, or this whole fantasy, get all the elements out on the table, and...look at the different elements and think--without the idea that we're looking for one explanation--"Oh my god, that's my father". You know?

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Clinician works with patient's/ client's dreams as clinical content	2	5.9	You know, Freud got discredited, and he's the guru of, obviously, psychoanalysis. You know the joke: ok you're on the couch, and you have to deal with dreams and everything else. But I did use dreams. And I used it sometimes when people were kind of at an impasse. And I'd just throw out a line, I'd say: do you ever have dreams? Or sometimes, somebody would come in and say "I didn't sleep well last night", I'd say "do you remember your dream?" I'd ask them to write it down. And I do think that sometimes—I mean it's not like getting out the dream book and saying "ok, if you dreamt of money that means you're thinking of sex" you know? But if you do it in the traditional analytic fashion of: I would write down their dream just as they said it, and then I'd ask them to associate with sort of each element of the dream, and then we'd talk about their associations to those elements.
CBT and psychodynamic techniques seen as naturally overlapping	2	5.9	Freud used to talk about [in] "on the importance of lay analysis"—his whole argument was: don't get caught in the theoretical, be more present in the affective. And again this was a later paper, when he started to advocate for, you know, systemic desensitization as we frame it now.
Sensate focus exercises may trigger developmental/ attachment issues	1	2.9	the early sensate focus exercises would put couples very much in touch with the difficulty of being touched. I mean, the only time you're touched in a non-demand, non-arousing way is as a baby when you're touched and cuddled and held and stroked, so it figures that when you start sensate focus and you're touched and cuddled and held and stroked, that those sort of early issues are going to surface as well"

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Therapist challenging client defenses too much/soon risks reinforcing them	1	2.9	The other thing [I focus on] is defenses. Both couple and individual defenses. And the importance of recognizing those in sessions, and...don't challenge them too heavily, you'll just reinforce them.
Importance of (both couple and individual) defense mechanisms	6	17.6	what interests me is the defenses that I see. Couples therapy is somewhat different defensively, because you get two people's psychology at the same time. So you witness the defensive behaviour of the couple with each other in real time…[for example] one partner is not telling me about some passive aggressive defense they've used out there in the world, but is being passive aggressive in the moment with their partner.
Displacement	1	2.9	Displacement is a huge one. So often you're going to see people changing subjects, becoming uncomfortable, and all of a sudden we're arguing about the dog as opposed to sex.
Intellectualization	1	2.9	Another defense that comes up...would be intellectualization. So, a person comes up with this abstract, generalized explanation for something in their life. So: "it's not really that it's a sexual problem. I'm really tired. There's a whole bunch of things going on in my life" and on and on...also the way I described, it could sound like a rationalization—and so there's this kind of quality where we want to argue ourselves out of the point, that this is an issue

Table 9.4 (continued)

Themes/sub-themes	Interviewees discussing theme/sub-theme		Representative/Characteristic Statements
	Number	Percent (%)	
Therapist examines/ considers client's inner conflicts about sex (i.e. values, behaviours, beliefs, and meanings)	2	5.9	Erotic conflicts are more that a person may have an erotic turn on, an erotic interest, a sexual response to a particular stimuli, and they may find it repugnant that they feel excited by that, they may feel very conflicted, they may feel ashamed, they may feel incredibly aroused by it, but at the same time judge it very harshly, stigmatize their turn on, and be very alone and conflicted with that. You know, people who have been in marriages for 25 years and have had particular sexual interests, and turn ons they've been terrified to bring to their spouse, for fear of rejection, or disgust.
Somatization seen as important in sexual problems	1	2.9	I think all the defenses are important, really. You know, when I teach on the psychodynamic module I list all the defenses and talk about the ways in which they manifest in sexual problems. I suppose somatization is very important.